

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

04538

P

Reg. Dist. No. 43

1. PLACE OF DEATH:

County Baltimore
City or town Baysburg
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 8 West Overlea Ave.
Stay in hospital or inst. (yrs., or mos., or days) -
Stay in this community (yrs., or mos., or days) -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Baltimore
City or town Baysburg Ward No. -
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 8 West Overlea Ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR -

3. (a) FULL NAME

Maria Dell Acqua

3. (b) Social Security Number

4. Sex F 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Joseph Dell Acqua

6. (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) Oct 1 1871

8. AGE: Years 75 Months - Days - If less than one day - hrs. - min.

9. Birthplace - (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business -

12. Name Unknown

13. Birthplace Unknown

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Louis Dell Acqua

Address 8 West Overlea Ave.

17. Burial Date thereof May 31 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Holy Redeemer

Location Belair Road

18. Funeral director Our Funeral Home Inc

Address 4644 York Rd #12

19. 5/28/46 A.W. Hedrich
(Date rec'd by registrar) Registrar DM

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27th 1946 at - M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from no attending physician and that I last saw him alive on - 19 -

Immediate cause of death -

DURATION

coronary thrombosis Death
Due to immediately

arterio-sclerosis signs
Due to -

Other conditions -

(Include pregnancy within 8 months of death)

Major findings:

Of operations -

Of autopsy -

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide OK'd by Dr. R.E. Hedrick Date -

Where did injury occur? Baysburg (City or town) MD (County) MD (State)

Injured at home, farm, industry, public place (where?) -

Means of injury -

Injured at work? -

23. SIGNATURE

Robert E. Hedrick
Address 8 West Overlea Ave. Date signed 5/28/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04539

Reg. Dist. No. 32

1. PLACE OF DEATH:

County Baltimore
 City or town Mount Wilson
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 0 yrs., 8 mos., 17 days
 Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
 How long in hospital or institution? 0 yrs., 8 mos., 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore Co.
 City or town Pikesville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 18 Walker Avenue, Pikesville, Md.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Mrs. Madeline Adams

3. (b) Social Security Number

265-18-6333

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Charles Adams

6. (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.)

August 10, 1916

8. AGE:

Years
29Months
9Days
15

If less than one day

.....hrs.min.

9. Birthplace

Swansboro, North Carolina

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Cloud Howland

13. Birthplace

Swansboro, North Carolina

MOTHER

14. Maiden name

Lillie Dennis

15. Birthplace

Swansboro, North Carolina

16. Informant

Mrs. Madeline Adams

Address 18 Walker Ave., Pikesville, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof May 28, 1946
(month) (day) (year)Cemetery or crematory Swansboro, North CarolinaLocation Swansboro Cem., North Carolina

18. Funeral director

Frank H. Newell

Address Pikesville, Maryland19. May 25, 1946
(Date rec'd by registrar)
Earl J. Webster
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25, 1946 at 10:25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 8, 1945 to May 25, 1946
 and that I last saw him/her alive on May 25, 1946

Immediate cause of death

Pulmonary Tuberculosis

DURATION

1 Yr.
9 Mos.
Due to Tubercle Bacilli

Due to.....

Other conditions Tuberculous Laryngitis Unknown

(Include pregnancy within 3 months of death)

Major findings of operations No operation

.....Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Stewart A. Shaffer M.D. M. D. or otherAddress Mount Wilson, Md. Date signed 5/25/46

Rec'd - 5-29-46 Dr. E. E. Nichols

RECEIVED
MAY 30 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death cleanly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32P

CERTIFICATE OF DEATH

04540

Reg. Dist. No. 38

1. PLACE OF DEATH:
County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 Yrs.
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town 7901 York Rd.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME
Raymond Paine Allen

3. (b) Social Security Number
None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Emily Barry Allen
6. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 21, 1872
8. AGE: Years 73 Months 5 Days 10 If less than one day hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual occupation Architect - Self
11. Industry or business

12. Name L. W. P. Allen
13. Birthplace Maryland
14. Maiden name Mary Porter Paine
15. Birthplace Virginia

16. Informant Raymond P. Allen Jr.
Address Apt. 16 B. Fenway South Balto. 21 Md.

17. Burial Date thereof May 3, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Md.

18. Funeral director William J. Tickner & Sons
Address North & Pennsylvania Aves

19. 5-2 19 46 Aw Hadnick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 19 46 at 6:00 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 to April 30 19 46.
and that I last saw him alive on April 30 19 46

Immediate cause of death
Carcinoma (bladder) 1 1/2 yrs.
Due to
Due to
Other conditions

(Include pregnancy within 3 months of death)
Major findings of operations Carcinoma of bladder
Date of op. June 1945

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John Green M.D. M. D. or other
Address Baltimore - 4 - Md Date signed 5/1/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (312)

CERTIFICATE OF DEATH

04541

Reg. Dist. No. **4X**

1. PLACE OF DEATH

County **Baltimore**City or town **Fort Howard, Maryland**

(If outside city or town list village, RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Vets. Adm., Fort Howard, Maryland

How long in hospital or institution?

13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **Maryland** CountyCity or town **Baltimore**401 ~~414~~ S. High StreetStreet No. **World War II**

2.(a) If veteran, name war

3. (b) Social Security Number

218-18-4654

3. (a) FULL NAME

AMONICA Frank4. Sex **Male** 5. Color or race **White** 6.(a) Single, married, widowed, or divorced **Single**

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) **January 3, 1924**8. AGE: Years **22** Months **4** Days **23** If less than one day9. Birthplace **Baltimore, Maryland**10. Usual occupation **Unemployed**

11. Industry or business

12. Name **Vincent Anonica**13. Birthplace **Italy**14. Maiden name **Addaline Delana**15. Birthplace **Italy**16. Informant **Vets. Adm. Hosp., Ft. Howard, Md.**17. Burial (Burial, cremation, or removal. Which?) **May 29, 1946**Cemetery or crematory **Holy Redeemer**Location **Belair Rd. Baltimore Md.**18. Funeral director **Frank Della Nore**Address **52 N. Morley St.**19. **5/28/46** Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **26th May** 19 **46** at **10:00** M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **15th May** 19 **46** to **26th May** 19 **46**and that I last saw him alive on **26th May** 19 **46**

Immediate cause of death

Uremia, acute, severe **12 days**Due to **Nephritis, chronic, paren-****chymatous, severe** **5 mos.**

Due to

Other conditions **Secondary Anemia severe**

(Include pregnancy within 3 months of death)

Major findings of operations **Blood Transfusion**Date of op. **3-20-46**

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE **Samuel S. Frankel****VA, Fort Howard, Md.** M. D. **3-26-46**

Address Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48-6

CERTIFICATE OF DEATH

14542

Reg. Dist. No. 41

1. PLACE OF DEATH:

County Baltimore Co Ind
City or town Dundalk
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days) None

Stay in this community (yrs., or mos., or days) 2 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Balto County
City or town Dundalk Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 7528 Carroll Avenue
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR no

3. (a) FULL NAME

Alice K Anderson

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Charles E Anderson

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) April 5 1896

8. AGE: Years 70 Month 1 Days 14 If less than one day _____ hrs. _____ min.

9. Birthplace Balto Ind
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

12. Name John Maher
13. Birthplace Balto Ind

14. Maiden name Alice Maher Nelson

15. Birthplace Balto Ind

16. Informant Mrs. Viola Parker
Address 7528 Carroll Avenue

17. Burial Date thereof June 1 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Balto Cemetery
Location End of E North Avenue

18. Funeral director Albert L Hill Jr
Address 1606 N Chester Street

19. 5/31 19 46 A. W. Hedrick
(Date rec'd by registrar) Registrar D.M.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 19 46 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 19 46 to May 29 19 46 and that I last saw him alive on May 29 19 46

Immediate cause of death Carcinoma of uterus DURATION

Due to _____

Due to _____

Other conditions Arterio-Sclerosis
Chronic myocarditis & nephritis
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Walter A Anderson M. D. or other _____

Address 3001 Shanna Drive Date signed 5/30/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PHYSICIAN

Please underline the cause to which death should be charged statistically.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 163-A

CERTIFICATE OF DEATH

04543

P

Reg. Dist. No. 4X

1. PLACE OF DEATH:
County Balto.
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mo.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1021 Franklin Ave
(If rural, give LOCATION)
2.(a) If veteran, name war No.

3. (a) FULL NAME Frederick Appel.

3. (b) Social Security Number No.

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Lorina

7. Birth date of deceased (mo., day, yr.) June 24/1886 6.(c) If alive, give age 59 years

8. AGE: Years 59 Months 10 Days 7 If less than one day hrs. min.

9. Birthplace Baltimore - Md.
(Town, county, and state)

10. Usual occupation Retired Police

11. Industry or business Balto City

12. Name Frederick Appel

13. Birthplace Germany

14. Maiden name Gulbb

15. Birthplace Balto Md.

18. Informant Lorina Appel (wife)

Address 621 Franklin Ave

17. Burial Date thereof 5/14/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Md. Carmel

Location @ Donnell Street Road

18. Funeral director Sally Zeile

Address 403 S. Wolfe St.

19. 5-2 1946 Indemnity
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1946 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h. alive on 19

Immediate cause of death Manicure powder by gas

Due to Suppuration.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, IN in the following:

Accident, suicide, or homicide suicide Date of 5/1/46

Where did injury occur? Essex Balto. Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) at home.

Means of injury Gas from stove Injured at work? No

23. SIGNATURE Dr. M. J. D.

Address Deputy Medical Examiner

Date signed 5/1/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. **36**

1. PLACE OF DEATH:

County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since April 26, 1940
Hospital, institution, or street address where death occurred:
SHEPPARD AND ENOCH PRATT HOSPITAL
How long in hospital or institution? Since April 26, 1940

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State West Virginia County Raleigh
City or town Beckley
(If outside city or town limits, write RURAL and give nearest town)
Street No. 412 S. Kanawha St.
(If rural, give LOCATION)
2.(a) If veteran, name war None ✓

3. (a) FULL NAME

ROBERT TAYLOR BAIR

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Mabel Kent Bair

6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) September 10, 1880

8. AGE: Years 65 Months 8 Days 18 If less than one day _____ hrs. _____ min.

9. Birthplace Washington College, Wash. Co., Tenn.
(Town, county, and state)

10. Usual occupation Proprietor

11. Industry or business Lumber & automobile business

12. Name George W. Bair

13. Birthplace Virginia

14. Maiden name Mary Beard

15. Birthplace Tennessee

16. Informant HOSPITAL RECORDS

Address Sheppard-Pratt Hosp., Towson 4, Md.

17. Removal Date thereof May 30, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Keyser Funeral Home

Location Beckley, W. Virginia

18. Funeral director John Baird, Sons

Address Towson, Maryland

19. 5/29 19 46 G. W. Bacon
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28, 1946 at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 26, 1940 to May 28, 1946

and that I last saw him alive on May 28, 1946

Immediate cause of death Cerebral hemorrhage or hemiplegia and causes unspecified, 4 days

Due to General Paresis Unk.

Due to Generalized arteriosclerosis including brain Unk.

Other conditions Diabetes

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results Arteriosclerosis (no other gross find-) Date of op. _____

PHYSICIAN: Please underline the cause to which death should be charged statistically. ings.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Harry W. Mearns M. D. or other _____

Address Sheppard-Pratt Hospital Date signed 5/29/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11313

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE OF CALIFORNIA

POSTAL ADDRESS

RECEIVED
JUN 1 1946
BUREAU VI

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Bacon
Taylor Ave.

MARYLAND STATE DEPARTMENT OF HEALTH

~~STATE OF MARYLAND~~

CERTIFICATE OF DEATH

Registered No. 38

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 8023 Dalesford Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore - Parkville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8023 Dalesford Road
(If rural give location)
(e) If foreign born, how long in U. S. A? years

3 (a) FULL NAME

Harry Calvin Barnes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife Mary Catherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1874

8. AGE: Years Months Days If less than one day
71 8 8 hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

12. Name George Barnes

13. Birthplace ?

14. Maiden Name ? Smith

15. Birthplace ?

16 (a) Informant Mrs. Mary C. Barnes

(b) Address 8023 Dalesford Road

17 (a) Burial (b) Date thereof 5/9/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Moreland Park
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck

(b) Address 5305 Harford Road

19 (a) 5/8/46 (b) A. M. Bacon
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7th, 1946 at 12 noon M

21. I certify that death occurred on the date above stated; that I attended deceased from April 12, 1946, to May 7, 1946, and that I last saw him alive on May 6, 1946

Immediate cause of death

Hemiplegia, left

Due to Hypertension
& chronic myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. M. Bacon M. D.
Address 2810 Taylor Ave. Date signed 5/8/46

Duration

22 days

?

?

1

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(B2)

04545

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County Baltimore
 City or town Woodensburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 17 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Woodensburg County Balto.
 City or town
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Millie Ellsworth Barrick

3. (b) Social Security Number

June

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband

Milton S. Barrick

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

12 June 1862

8. AGE:

Years

Months

Days

If less than one day

83110

hrs.

min.

9. Birthplace

Baltimore City, Maryland
(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

MOTHER
FATHER
MOTHER

12. Name

William S. Mabbett

13. Birthplace

Utica, New York

14. Maiden name

Margaret A. McCullam

15. Birthplace

Frederick County, Md.

16. Informant

Mrs. Kate I. Tracy, Sister

Address

Reisterstown, Md.

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

May 14, 1946
(month) (day) (year)

Cemetery or

Emory Church

Location

near Finksburg

18. Funeral director

Wm. Berryman & Son

Address

Reisterstown, Md.

19.

5-13 19 46
(Date rec'd by registrar)Dary B. E. Line

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

5-12-46 19 46 at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-1-35 19 35 to 5-13-46 19 46and that I last saw her alive on 5-12-46 19 46

Immediate cause of death

Uremia (coma)

DURATION

3 days

Due to

Nephritis - Chronic

Due to

Hypertension

Other conditions

Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James L. Safely

M. D. or other

Address

ReisterstownDate signed 5/3/46

RECEIVED

U.S. DEPARTMENT OF HEALTH

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RECEIVED

MAY 15 1946

BUREAU V. H.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-5

CERTIFICATE OF DEATH

04547 38

Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
 City or town Towson 4, Maryland
 (if outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Sept 28, 1944
 Hospital, institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Md.
 How long in hospital or institution? since Sept 28, 1944

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Essey
 (if outside city or town limits, write RURAL and give nearest town)
 Street No. Baltimore, R.D. 16 (Zone 21)
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Amelia Marion Batis
 4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife George D Batis

7. Birth date of deceased (mo., day, yr.) June 10, 1901 6.(c) If alive, give age years

8. AGE: Years 44 Months 11 Days 16 It less than one day hrs. min.

9. Birthplace Austria
 (Town, county, and state)

10. Usual occupation seamstress11. Industry or business Social Security No- 212-01-591512. Name Andrew Cisunko13. Birthplace Austria14. Maiden name Katharine Madley15. Birthplace Austria

Personal History- Hospital Records

16. Informant Eudowood Sanatorium, Towson 4, Md.
 Address

17. Burial Date thereof May 29, 1944
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Moreland Memorial ParkLocation Baltimore, Md.18. Funeral director Wm. Cook Inc.Address 1217 St Paul St. Balt.

19. 5/27/44 6 Cec. H. H. H.
 (Date recd by registrar) (Signature)

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26, 1944 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 28, 1944 to May 26, 1944
 and that I last saw him alive on May 25, 1944

Immediate cause of death

DURATION

Pulmonary tuberculosis since April 1944
 Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W.A. Bridges M. D. or otherAddress Towson 4, Maryland Date signed 5-26-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

CERTIFICATE OF DEATH

04548

Reg. Dist. No. 37

1. PLACE OF DEATH:

County Baltimore
 City or town Cockeysville Md
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs
 Hospital, institution, or street address where death occurred:

Masonic Home, Cockeysville Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 1207 E. North Ave.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Caroline E. Blackburn

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Widow

6.(b) Name of husband or wife Arthur Blackburn

7. Birth date of deceased (mo., day, yr.) Aug. 5, 1878 6.(c) If alive, give age: years

8. AGE: Years 67 Months 9 Days 19 If less than one day: hrs. min.

9. Birthplace Baltimore Md
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name John Conrad Eber
 13. Birthplace Germany

14. Maiden name Caroline E. Haase
 15. Birthplace Germany

16. Informant Laura M. Schroeder
 Address Masonic Home, Cockeysville Md

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof May, 27, 49
 (month) (day) (year)

Cemetery or crematory Oak Lawn
 Location Baltimore

18. Funeral director Wm. Cook
 Address St. Paul & Preston St

19. May 24 19 46 Laura M. Schroeder
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 19 46 at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 18 19 46 to May 24 19 46 and that I last saw him alive on May 24 19 46

Immediate cause of death

Coronary Occlusion & Thrombosis in Coronary

DURATION

6 days

Due to

Hypertensive Cardiovascular disease

Due to

3 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Walter J. Kuss M.D.
Powers Argemont M.D. or other
 Address Cockeysville Md Date signed 5/24/46

RECEIVED
MAY 28 1946
BUREAU V 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Bd*

04549

CERTIFICATE OF DEATH

Reg. Dist. No. *35-*

1. PLACE OF DEATH:

County *Baltimore*
 City or town *Rural near Parkton*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *42 yrs.*
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State *Maryland* County *Baltimore*
 City or town *Rural near Parkton*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *Bentley Springs*
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Daniel Howard Bollinger

3. (b) Social Security Number

216-10-1831

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

*Male White Married*6.(b) Name of husband or wife *Nina May**Bollinger* 6.(c) If alive, give age *63* years7. Birth date of deceased (mo., day, yr.) *July 24, 1874*8. AGE: Years Months Days If less than one day
71 9 19 hrs. min.9. Birthplace *Parkton, Md. R.D.*
(Town, county, and state)10. Usual occupation *Machinist*11. Industry or business *Paper mill*12. Name *Valentine Bollinger*13. Birthplace *Germany*14. Maiden name *Lydia Smith*15. Birthplace *Md.*16. Informant *Mrs. Benjamin Cummings*Address *Bentley Springs, Md.*17. Burial (Burial, cremation, or removal. Which?) Date thereof *May 15, 1946*
(month) (day) (year)Cemetery or crematory *Mt. Zion*Location *Freeland, Balto. Co., Md.*18. Funeral director *Jacob Hartenstein*Address *New Freedom, Pa.*19. *May 14* 19 *46* *Charles L. Fisher*
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH *May 13, 1946* at *11:00 A.M.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Aug 30* 19 *41* to *May 13* 19 *46*and that I last saw him alive on *May 12, 1946* 19 *46*Immediate cause of death *Arteriosclerosis**Cardio-vascular Disease* DURATION *6 yrs*Due to *arteriosclerosis*Due to *arteriosclerosis*

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE *Paul J. Shant* M. D. or otherAddress *Shrewsbury, Pa.* Date signed *5-18-46*

RECEIVED
JUN 5 1946
BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County... Baltimore
 City or town... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 11 months, 17 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 11 months, 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County.....
 City or town... Baltimore-13
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2001 East Lafayette Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Frank Morrison Boyd

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Ethel Scott
 6.(c) If alive, give age 51 years
 7. Birth date of deceased (mo., day, yr.) January 6, 1890
 8. AGE: Years 56 Months 4 Days 11 If less than one day
 hrs. min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)
 10. Usual occupation Salesman
 11. Industry or business Manufacturing companies
 12. Name Clarence Boyd
 13. Birthplace Maryland
 14. Maiden name Virginia Royston
 15. Birthplace Maryland

16. Informant Hospital records
 Address Catonsville-28, Maryland
 17. Burial Burial Date thereof 5-20-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Parkwood Cemetery
 Location Baltimore, Maryland
HENRY SANDER & SONS, INC.
 19. Funeral director NORTH AVE. & BROADWAY
 Address

18. 5/20/46 Registrar
 (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 19 46, at 10:00 a.m.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 30 1945, to May 17 1946
 and that I last saw him alive on May 17 1946
 Immediate cause of death General paresis

DURATION Indefinite
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....
 Autopsy results none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
Isidore Tuerk
Isidore Tuerk, M.D.
 23. SIGNATURE..... M. D. or other
 Address Catonsville-28, Md. Date signed 5-17-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (3d)

Registered No. 04551

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 5501 Edmonds on Ave

(c) Hospital or institution:

Good Convalescent Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) wife

2. USUAL RESIDENCE OF DECEASED:

(a) State: Maryland County

(c) City or town: Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 26 N. Monastery Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

GENA E. BREITENOTER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife: Louis H.

6 (c) If alive, give age 8 years

7. Birth date of deceased (mo., day, yr.) 12-29-1895

8. AGE: Years 70 Months 4 Days 27 hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: AT HOME

12. Name: Lambert Teuthe

13. Birthplace: GERMANY

14. Maiden Name: Nettie Kispeit

15. Birthplace: GERMANY

16 (a) Informant: Mrs. Wm. H. Schwab

(b) Address: 26 N. Monastery

17 (a) Burial (b) Date thereof: 5/29/46

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory: Western

Location: Baltimore City

18 (a) Funeral director: J. P. Skippert

(b) Address: 1300 E. G. Place

19 (a) 5-29-46 (b) Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 25 May 1946, at 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1941, to May 25, 1946, and that I last saw her alive on May 22, 1946.

Immediate cause of death: Cerebral hemorrhage

Due to: Arteriosclerotic C.V.D.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature: J. P. Skippert

Address: 3325 Frederick Ave

Date signed: 5/28/46

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 195-2

CERTIFICATE OF DEATH

14552

Reg. Dist. No. 32

1. PLACE OF DEATH:

County BaltimoreCity or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 yr.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)Street No. Reisterstown & Keller Rds
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Edward Lancaster Brewster Jr.

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

B. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

April 19, 1942

8. (c) If alive, give age

8. AGE:

Years

Months

Days

If less than one day

419hrs.min.

9. Birthplace

Westbury, R. Island

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

Edward L. Brewster

13. Birthplace

Lake Forest, Illinois

MOTHER

14. Maiden name

Kathleen Malloy

15. Birthplace

Baltimore, Maryland

16. Informant

Edward L. Brewster

Address

Pikesville, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

May 31, 46
(month) (day) (year)

Cemetery or crematory

Mt. Olive

Location

Fredrick Rd. Balto. Md

18. Funeral director

Frank N. Newell

Address

Pikesville, Maryland

19.

5-31-46

(Date rec'd by registrar)

19. 46Dr. E. E. Nichols

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28, 1946 at 7:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5-2819-46to 5-2819-46and that I last saw him in bed on 5-28 19-46

Immediate cause of death

Gas explosion in kitchen at home
Second degree Burns of Feet

DURATION

20 min

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5-28-46Where did injury occur? Pikesville Balto. Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury Gas Explosion Injured at work? No23. SIGNATURE D. D. D. Caples, Med. Exam.

M. D. or other

Address Reisterstown, Md. Date signed 5-30-46

ILLINOIS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
JUN 1 1946
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1952

CERTIFICATE OF DEATH

04553

Reg. Dist. No. 32

1. PLACE OF DEATH:

County Baltimore
 City or town Pikeville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 yr
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Pikeville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Reisterstown Road
 (If rural, give LOCATION) Kedar Rd.
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Kathleen Malloy Brewster

3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Edward L. Brewster

7. Birth date of deceased (mo., day, yr.)

May 20, 19146. (c) If alive, give age 32 years

8. AGE:

Years

Months

Days

If less than one day

328

hrs.

min.

8. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

John F. Malloy

13. Birthplace

Philadelphia, Pa.

MOTHER

14. Maiden name

Minnie W. Colby

15. Birthplace

Baltimore, Maryland

16. Informant

Edward L. Brewster

Address

Pikeville, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

May 31, 1946

Cemetery or crematory

Mt. Olive

Location

Frederick Rd. Balt. Md.

18. Funeral director

Frank H. Hurrell

Address

Pikeville Maryland

19.

(Date rec'd by registrar)

19.

5-31-46D. E. Nichols

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1946, at 7:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 28 1946 to May 28 1946and that I last saw alive on May 28 1946

Immediate cause of death

Explosion in kitchen at homeSecond degree burns oflegs, abdomen & arms

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations

None

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5-28-46Where did injury occur? Pikeville Balt. Md.

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) HomeMeans of injury Gas Explosion Injured at work? No.

23. SIGNATURE

D. D. Cooper, M.D.

M. D. or other

Address Reisterstown Md. Date signed 5-30-46

RECEIVED

JUN 1 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

14554

CERTIFICATE OF DEATH

★ Reg. Dist. No. 39

1. PLACE OF DEATH:

County Baltimore
 City or town Sunnybrook Phoenix
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Baltimore
 City or town Sunnybrook,
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Phoenix P.O.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

John Eusor Brown

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Elizabeth R.

7. Birth date of deceased (mo., day, yr.) March 24, 1854 6.(c) If alive, give age — years

8. AGE: Years 92 Months 1 Days 8 If less than one day
 .hrs. .min.

9. Birthplace Ohio
 (Town, county, and state)

10. Usual occupation Builder & contractor

11. Industry or business

12. Name John Brown13. Birthplace unknown14. Maiden name unknown15. Birthplace unknown16. Informant Mrs. Clara WolfeAddress Phoenix Md.

17. Burial Date thereof May 5, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fairview MethodistLocation Sunnybrook, Phoenix Md.18. Funeral director Lauson M. BrooksAddress Sparks, Md.19. May 4 19 46 Anna Price

(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 19 46 at 11 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 - 44 to May 2 - 46and that I last saw him alive on Apr. 30 19 46Immediate cause of death Coronary ThrombosisDue to Myocarditis -Due to arteriosclerosis -

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

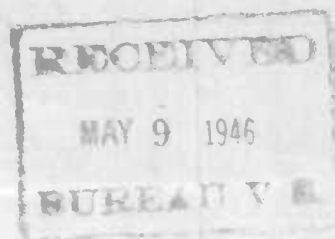
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William C. Eusor M.D.Address Cheysville Md. Date signed 5/9/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Grott
8100 Harford Rd.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 98-1

CERTIFICATE OF DEATH

04556

Reg. Dist. No. 38

1. PLACE OF DEATH: County <u>Parkville</u> City or town <u>Baltimore</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: <u>8325 Harford Road</u> How long in hospital or institution?			2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Parkville</u> City or town <u>Baltimore</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>8325 Harford Road</u> (If rural, give LOCATION) 2. (a) If veteran, name war		
3. (a) FULL NAME <u>Mary F. Buccheri</u>			3. (b) Social Security Number		
4. Sex <u>female</u>	5. Color or race <u>white</u>	6. (a) Single, married, widowed, or divorced <u>married</u>			
6. (b) Name of husband or wife <u>G. L. Buccheri</u>					
6. (c) If alive, give age _____ years					
7. Birth date of deceased (mo., day, yr.) <u>May 14, 1872</u>					
8. AGE: Years <u>73</u>	Months <u>11</u>	Days <u>23</u>	If less than one day _____ hrs. _____ min.		
9. Birthplace <u>Baltimore, Md.</u> (Town, county, and state)					
10. Usual occupation <u>at home</u>					
11. Industry or business					
FATHER					
12. Name <u>Mohn Sindall</u>					
13. Birthplace <u>Md.</u>					
MOTHER					
14. Maiden name <u>Margaret V. Tillet</u>					
15. Birthplace <u>Md.</u>					
16. Informant <u>Mr. G. L. Buccheri</u> Address <u>8325 Harford Road</u>					
17. Burial Date thereof <u>5/9/46</u> (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematory <u>Parkwood</u> Location <u>Baltimore</u>					
18. Funeral director <u>Leonard J. Ruck</u> Address <u>5305 Harford Road-14-</u>					
19. <u>May 8</u> 19 <u>46</u> <u>A. M. Boeue</u> (Date rec'd by registrar) Registrar					
MEDICAL CERTIFICATION					
20. DATE OF DEATH <u>May 7th,</u> 19 <u>46</u> at <u>6:00 P.M.</u>					
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>9 am. 1</u> 19 <u>45</u> to <u>May 7,</u> 19 <u>46</u> and that I last saw him alive on <u>May 6,</u> 19 <u>46</u>					
Immediate cause of death <u>acute pulmonary edema</u>					
Due to <u>Hypertension cardiac -</u>					
Due to <u>vascular disease</u>					
Other conditions _____					
(Include pregnancy within 8 months of death.)					
Major findings of operations _____					
Date of op. _____					
Autopsy results _____					
PHYSICIAN: Please underline the cause to which death should be charged statistically.					
22. VIOLENCE: If death was due to external causes, fill in the following:					
Accident, suicide, or homicide _____ Date of _____					
Where did injury occur? _____ (City or town) (County) (State)					
Injured at home, farm, industry, public place (where?) _____					
Means of injury _____ Injured at work? _____					
23. SIGNATURE <u>Harold A. Grott, M.D.</u> Address <u>8100 Harford Rd.</u> Date signed <u>5/8/46</u>					

RECEIVED

MAY 9 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Bacon

MARYLAND STATE DEPARTMENT OF HEALTH

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 38

4557

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: #3000 Arizona Avenue

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Parkville

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 3000 Arizona Avenue
(If rural give location)

(e) If foreign born, how long in U. S. A. ? years

3 (a) FULL NAME

Henry F. Buschman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

widowed

6 (b) Name of husband or wife

Mary Ann

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1 - 1866

8. AGE:

Years 80

Months 3

Days 8

If less than one day

hr.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

FATHER

12. Name

?

13. Birthplace

?

MOTHER

14. Maiden Name

?

15. Birthplace

?

16 (a) Informant Estate of Henry Buschman

(b) Address 3000 Arizona Avenue

17 (a) Burial (b) Date thereof 5/11/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Baltimore

Location

Baltimore

18 (a) Funeral director

Leonard J. Ruck

(b) Address

5305 Harford Rd.

19 (a) 5/10/46 (b) A. M. Bacon
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9th, 1946, at 4:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1935, to May 9, 1946, and that I last saw him alive on May 9, 1946.

Immediate cause of death

Chronic myocarditis
Hypertension
Due to arteriosclerosis

Duration

10 years
10 years
15 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature A. M. Bacon M. D.

Address 2810 Taylor Ave. Date signed 7/9/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93rd

04555

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore CountyCity or town Ruxton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 years

Hospital, institution, or street address where death occurred: _____

How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore CountyCity or town Ruxton
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

William Cabell Bruce

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife Louise Est. Fisher Brucedeceased 6. (c) If alive, give age _____ years7. Birth date of deceased (mo., day, yr.) March 12th 18608. AGE: Years 86 Months 1 Days 28 If less than one day _____ hrs. _____ min.9. Birthplace Charlotte County Va
(Town, county, and state)10. Usual occupation Lawyer, ex. U. S. Senator

11. Industry or business

12. Name Charles Bruce13. Birthplace Halifax Co. Va14. Maiden name Sally Seddon15. Birthplace Fredericksburg Va.16. Informant Wm C. FisherAddress 715 Park Ave Baltimore Md17. Burial Date thereof May 11 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Thomas ChurchLocation Garrison, Md.18. Funeral director H. Jenkins & Sons Co. Inc.Address 47th Calhoun & Orchard Sts. Baltimore19. 5-9 19 46 Wm C. Fisher
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1946, at 9²⁰ AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 2 1946 to May 9 1946and that I last saw him alive on May 8 1946Immediate cause of death Myocardial infarctionDue to Arteriosclerosis, GeneralizedDue to Paralysis AgitansOther conditions 1

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Wm C. Fisher M. D. or other _____Address 18 E Eager St Date signed May 9 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

evidence for the change of
year of birth shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

★ 4558

Reg. Dist. No. 32

FILM No. I 06 JUL 17 1946

1. PLACE OF DEATH:

County Baltimore
City or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1102 Reisterstown Rd
(If rural, give LOCATION)
2.(a) If veteran, name war no

3. (a) FULL NAME

Joseph Henry Bushmiller

3. (b) Social Security Number

218-03-5362

4. Sex Male 5. Color of race white 6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife Mrs E. Bushmiller
7. Birth date of deceased (mo., day, yr.) Dec. 22 - 1894 1893
8. AGE: Years 52 Months 4 Days 18 If less than one day
.....hrs.min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual occupation Clerk

11. Industry or business Baltimore County, Md

12. Name Henry Bushmiller

13. Birthplace Germany

14. Maiden name Elizabeth Buddie

15. Birthplace Germany

16. Informant Mrs E. Bushmiller

Address 1102 Reisterstown Rd. Pikesville

Burial Date thereof May 14 - 46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory New Cathedral

Location Edmond + Frederick Rds

16. Funeral director Grant H. Newell

Address Pikesville, Maryland

19. 5-13-1946 Dr E E Nichols
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9th 1946, at 10:15 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5th 1946, to May 9th 1946, and that I last saw him alive on May 9 1946.

Immediate cause of death Coronary Thrombosis DURATION 5 days

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E E Nichols, MD M. D. or other

Address Pikesville 8th Date signed 5/13/46

RECEIVED
MAY 16 1946
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

C4559

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County BaltimoreCity or town Fork and
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County BaltoCity or town Fork md.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Julie C. Busick

3. (b) Social Security Number

4. Sex

F

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

married

B. (b) Name of husband or wife

Robert H. Busick

7. Birth date of deceased (mo., day, yr.)

mdc 25-1898

B. (c) If alive, give age _____ years

8. AGE:

48

Years

1

Months

Days

If less than one day

_____ hrs. _____ min.

9. Birthplace

Troy N. Y.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Timothy Dwyer

13. Birthplace

Troy N. Y.

14. Maiden name

Catherine Cunningham

15. Birthplace

Ireland

16. Informant

Robert H. Busick

Address

Hyde md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

mdc 25-46
(month) (day) (year)

Cemetery or crematory

St. Josephs

Location

Troy New York

18. Funeral director

Clarence E. Arthur

Address

Fork md.

19.

(Date rec'd by registrar)

May 23 19 46B. E. Arthur
District

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 19 46 at 4:55 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 8, 19 44 to May 22 19 46and that I last saw him alive on May 22 19 46

Immediate cause of death

Carcinoma of L.
Breast with
metastases to spine, 3 yrs
medastinum and
lung

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations Advanced CarcinomaDate of op. 19 44

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

Clifford F. Hudson, MD
Fork md.

M. D. or other _____

Address _____ Date signed 5/23/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 29 1946

BUREAU V.S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

4560 P

1. PLACE OF DEATH

County Baltimore

Village or City Dundalk

Registration Dist. No. 41

No. 222 8th Helena Ave Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME

William Buttz (BUTZ)

(a) Residence: No. 222 8th Helena Ave St. Ward.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of <u>Ida V.</u>		
6. DATE OF BIRTH (month, day, and year) <u>May 24/1873</u>		
7. AGE Years <u>72</u>	Months <u>11</u>	Days <u>29</u>
8. Trade, profession, or particular kind of work done, as SPINNER SAWYER, BOOKKEEPER, etc. <u>Machine operator</u>		
9. Industry or business in which work was done, as SILK MILL SAW MILL, BANK, etc. <u>Schmidt Bakery</u>		
10. Data deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Baltimore Md.
(State or country)

13. NAME John George P. M. Butz

14. BIRTHPLACE (city or town) Germany
(State or country)

15. MAIDEN NAME Dorothea Matronich

16. BIRTHPLACE (city or town) Germany
(State or country)

17. INFORMANT Mrs Lilbon M. Garrett
(Address) 655 18th Brown St

18. BURIAL, CREMATION, OR REMOVAL
Place Green Park Date 5/25, 1946

19. UNDERTAKER Thalborn & Son
(Address) 1214 21st Ave

20. FILED 5/25, 1946 Over Hedding
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

May 22, 1946
(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from May 22/46 to May 22/46

I last saw him alive on _____, 19____; death is said

to have occurred on the date stated above, at _____ m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Coronary occlusion

Other Contributory Causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____

(Specify city or town, county and State)

Specify whether injury occurred IN INDUSTRY, IN HOME, or in PUBLIC PLACE.

Manner of injury _____

Nature of Injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify _____

(Signed) M. M. M. M. M. M. D.

(Address) Deputy Medical Examiner

If more blanks are needed, address State Registrar, 241 N. Charles Street, Baltimore, Maryland, U. S. No. _____

MARGIN RESERVED FOR BINDING

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
-------------------	--------------------

Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
------------------------	---------------

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

04561

Reg. Dist. No. 47

1. PLACE OF DEATH:

County Baltimore
 City or town Bowleys Quarters
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Seven years
 Hospital, institution, or street address where death occurred: at home
 How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md County Balto.
 City or town Bowleys Quarters
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Glenwood Road
 (If rural, give LOCATION)
 2(a) If veteran, name war (no)

3. (a) FULL NAME

Marie Wentz Calvert

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife John H. Calvert
 6. (c) If alive, give age 37 years
 7. Birth date of deceased (mo., day, yr.) May-9-1911
 8. AGE: Years 34 Months 11 Days 27 If less than one day _____ hrs. _____ min.

9. Birthplace Pennsylvania
 (Town, county, and state)

10. Usual occupation housewife

11. Industry or business _____

12. Name Walton M. Wentz

13. Birthplace Lindero - md.

14. Maiden name Fannie Koutz

15. Birthplace Spring Grove - Pa.

16. Informant Mr. H. H. Calvert - (husband)

Address Bowleys Quarters

17. Burial Date thereof May-9-46
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Parkwood

Location Parkville - Balto.

18. Funeral director Stewart Mort Co.

Address 108 W. North Ave.

19. 5/8 19. 46 Baltimore
 (Date rec'd by registrar) (year) (city)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 19 46 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8 19 45, to May 6 19 46

and that I last saw him alive on 19

Immediate cause of death generalized malnutrition

DURATION

14-18

months

Due to generalized metastasis from carcinoma of the breast, right

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of breast, right

Date of op. July 9, 1945

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE T. Edgie Russell, Jr.

M.D. M. D. or other _____

Address 101 E. Baltimore Date signed 5-8-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 14562 37

1. PLACE OF DEATH:

County Baltimore
 City or town Towson
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? working place
 Hospital, institution, or street address where death occurred

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Baltimore
 City or town Towson 4
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 117 E. Chesapeake
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Wilbert Abraham Causon

3. (b) Social Security Number

219-01-3999

4. Sex

m

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Sarah Gardner

7. Birth date of

deceased (mo., day, yr.)

Jan 22, 19056. (c) If alive, give age 35 years

8. AGE:

Years	Months	Days	If less than one day
<u>41</u>	<u>3</u>	<u>18</u>	hrs. min.

9. Birthplace

Sparks, Balto. Co. Md.
(Town, county, and state)

10. Usual occupation

laborer & janitor

11. Industry or business

quarry

FATHER

12. Name

Clarence Brian

13. Birthplace

Balto. Co. Md.

MOTHER

14. Maiden name

Ladie Causon

15. Birthplace

Sparks, Balto. Co. Md.

16. Informant

Sarah Gardner Causon

Address

117 E. Chesapeake Ave.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 5 12 46
(month) (day) (year)

Cemetery or crematory

Stephenson Chapel

Location

Sparks, Md.

18. Funeral director

Towson M. Brooks

Address

Sparks, Md.

19. (Date rec'd by registrar)

May 11 1946Wilmer C. Ensor

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH

May 9 1946 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h

Immediate cause of death

Asphyxiation

DURATION

5/9/46

Due to

Accident. Fell into cement vault5/9/46

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5/9/46

Where did injury occur?

Towson Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Cypress Hill many drunk

Means of injury

Fell in cement vault Injured at work? yes

23. SIGNATURE

Bollin C. Hudson M.D.

M. D. or other

Address

Towson Md.Date signed 5/9/46

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

REC-1

MAY 14 1946

MURKIN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-6

CERTIFICATE OF DEATH

Reg. Dist. No. 04563, 8

1. PLACE OF DEATH:

County Baltimore
 City or town Towson 4, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since March 24, 1944
 Hospital, institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Md.
 How long in hospital or institution? Since March 24, 1944

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Balto City
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 907 E. Lombard St.
 (If rural, give LOCATION)
 2.(c) If veteran, name war ☒

3. (a) FULL NAME

Martha Chinn (Martha CHIN)

3. (b) Social Security Number

4. Sex Female 5. Color or race Chinese 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Nov. 10, 1929
 8. AGE: Years 16 Months 6 Days 18 It less than one day _____ hrs. _____ min.

9. Birthplace Baltimore Md.
 (Town, county, and state)
 10. Usual occupation School girl
 11. Industry or business
 12. Name Hsuey Chinn
 13. Birthplace Canton, China
 14. Maiden name Emma Horn
 15. Birthplace Maryland

Personal History- Hospital Records

16. Informant
 Address Eudowood Sanatorium, Towson 4, Md.
 17. Burial Date thereof 5-30-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Lanham
 Location Woodlawn
 18. Funeral director Sheward Monahan Co.
 Address 108 W. North Ave.
 19. 5-29 19 46 Quaker
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1946 at 8:45-9 M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 24 1946 to May 28 1946
 and that I last saw her alive on May 27 1946
 Immediate cause of death Pulmonary tuberculosis
 Due to Since about April 1943
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide
 Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE W A Bridge M. D. or other
 Address Towson 4, Maryland Date signed 5-28-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 04565

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address Edmondson Ave. & Nunnery Lane
(c) Hospital or institution: The Opitz Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2312 Boston Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.

3 (a) FULL NAME

JULIAN CHRZANOWSKI

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married6 (b) Name of husband or wife Bertha (Bronislaw)6 (c) If alive, give age 54 years7. Birth date of deceased (mo., day, yr.) May ? 18858. AGE: Years Months Days If less than one day
61 hr. min.9. Birthplace Chrzanow, Poland
(Town, county, and state)10. Usual Occupation Proprietor11. Industry or business TavernFATHER
MOTHER12. Name Peter Chrzanowski13. Birthplace Chrzanow, Poland14. Maiden Name Teofila Kolakowska15. Birthplace Chrzanow, Poland16 (a) Informant Mrs. Bertha Chrzanowski(b) Address 2312 Boston Street17 (a) Burial (b) Date thereof 5/8/46
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory St. StanislausLocation Mt. Carmel Road18 (a) Funeral director M. J. Sedowski & Son(b) Address 1808 Eastern Avenue19 (a) 5-7-46 (b) As Noted
(Date rec'd by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1946, at 10:45 P.M.21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 6 1945, to May 4 1946, and that I last saw him alive on May 3 1946.

Immediate cause of death

myocardial insufficiency
toxicosis
Due to left hemiplegiaDue to hypertension, arterio-sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury Subarachnoid
23. Signature R. C. Obitual

Address 447 W. Kenwood Ave. Date signed 5/8/46

Duration

3 days
2 mo.
7 mo.

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

4566

Reg. Dist. No. 32

1. PLACE OF DEATH:

County Balto
 City or town Pikesville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 Years.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
 City or town Pikesville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Woodholme Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

BESSIE SKUTCH CONE.

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow
 6.(b) Name of husband Dr. Sydney M. Cone.
 7. Birth date of deceased (mo., day, yr.) June 9th. 1880.
 8. AGE: Years 65 Months 11 Days 7 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Max Skutch.
 13. Birthplace Bavaria.
 MOTHER 14. Maiden name Fannie Frank.
 15. Birthplace Balto. Md.

16. Informant Mr. Maxwell Cone.
 Address Woodholme Ave.

17. Cremation Date thereof May 20th. 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Loudon Park.
 Location Balto. Md.

18. Funeral director David Soudaheim & Son
 Address 1902 Eutaw Place.
Balto. Md.

19. 5/18 1946 Dr. W. Ledrich
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16th. 19 46, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1945 to May 16 1946
 and that I last saw him alive on May 16, 1946

Immediate cause of death _____ DURATION _____
Carcinomatosis about 15 mos.
 Due to Carcinoma of Stomach
 Due to (Symptoms) abt 18 mos.
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma - pyloric end of stomach; gastro-intest. Date of op. Feb. 26, 1945

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Louis P. Hamburger M.D. or other _____
 Address 1207 Eutaw Place. Date signed May 17, 46
Balto. Md.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

MAY 18 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AGE: Dr. Fisher's letter filed 6-7-46 G05 LL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

County BaltimoreCity or town Towson
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

225 W. Joppa Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Towson
(If outside city or town limits, write RURAL and give nearest town)Street No. 225 W. Joppa Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

John Jerome Crogan

3. (b) Social Security Number

4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Gertrude T. Crogan6. (c) If alive, give age 54 years7. Birth date of deceased (mo., day, yr.) August 14, 18918. AGE: Years 54 Months 9 Days 4 It less than one day — hrs. — min.9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation Real Estate Broker11. Industry or business Self12. Name Luke J. Crogan13. Birthplace Washington, D.C.14. Maiden name Elizabeth Fahy15. Birthplace Balto. Co., Maryland16. Informant Mrs. Gertrude T. CroganAddress 225 W. Joppa Rd., Towson 4, Md.17. Burial Date thereof May 21, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory New Cathedral Cem.Location Baltimore, Maryland18. Funeral director John Burns' SonsAddress Towson, Maryland19. May 20 19 46 Registrar [Signature]

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18, 19 46, at M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 1 - 19 46, to May 18, 19 46.and that I last saw him alive on May 18, 19 46.Immediate cause of death Coronary ThrombosisDue to Atherosclerosis

Other conditions

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. Murray FisherAddress 18 E. Eager St.Date signed 5/19/46

Balto.

RECEIVED
JUN 2 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH

of deceased & birth date of deceased 2411 N. Charles St., Baltimore 83-6

FILM No. I 0 4 MAY 16 1946

CERTIFICATE OF DEATH

04568

Reg. Dist. No. XX

1. PLACE OF DEATH:

County Baltimore
City or town 717 F. STREET - SPARROWS PT., MD
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: _____

Stay in hospital or inst. (yrs., or mos., or days) _____

Stay in this community (yrs., or mos., or days) _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Baltimore
City or town SPARROWS PT. Ward No. _____
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 717 F. ST.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

Benjamin Thomas Dailey

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced WIDOWED

6. (b) Name of husband or wife NANIE VIRGINIA DAILEY

7. Birth date of deceased (mo., day, yr.) MAY 25 1866 1867

8. AGE: Years 78 Months 79 Days 11 If less than one day 15 hrs. _____ min. _____

9. Birthplace GLENCOE, MARYLAND
(Town, county, and state)

10. Usual occupation RECEIVING CLERK

11. Industry or business BETHLEHEM STEEL CO.

FATHER 12. Name SETH DAILEY
13. Birthplace BALTIMORE CO.

MOTHER 14. Maiden name DAVISON

15. Birthplace BALTIMORE CO

16. Informant MARGARET DAILEY

Address 717 F. ST. SPARROWS PT.

17. BURIAL Date thereof MAY 13, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory EMANUEL EPISCOPAL CEM.

Location GLENCOE, MD

18. Funeral director JOHN F. DENNY, INC

Address 715 LIGHT ST.

19. 5/11 19 46 A.W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 19 46, at 5:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 46, to May 10 19 46, and that I last saw him alive on May 10 19 46

Immediate cause of death

Cerebral Thrombosis

DURATION

3 days

Due to

Arteriosclerosis generalized

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____

Injured at work? _____

23. SIGNATURE

A.W. Hedrick M.D.

M. D. or other

Address 5-20 J St. Sp P Pt. Date signed 5.10.46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *57-d*

CERTIFICATE OF DEATH

Reg. Dist. No. *64*

1. PLACE OF DEATH:

County *Baltimore*City or town *Fort Howard*
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *107 days*

Hospital, institution, or street address where death occurred:

*Veterans Administration Hospital*How long in hospital or institution? *107 days*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Wilkes*City or town *Fruitland*
(If outside city or town limits, write RURAL and give nearest town)Street No. *Box 113*
(If rural, give LOCATION)2.(a) If veteran, name war *World War II* ✓

3. (a) FULL NAME

MATTHEW S. DASHIELL

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

*Single*6. (b) Name of husband or wife *Single*

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) *10/3/14*

8. AGE:

Years

31

Months

7

Days

20

If less than one day

_____ hrs. _____ min.

9. Birthplace *Fruitland, Md.*

(Town, county, and state)

10. Usual occupation *Laborer*

11. Industry or business

12. Name *Solomon Dashiell (deceased)*13. Birthplace *Maryland*14. Maiden name *Alice Humphries*15. Birthplace *Maryland*16. Informant *Clinical Records*Address *Vet. Hosp. Ft. Howard, Md.*17. *Burial* Date thereof *May 29-46*
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory *Not known*Location *Fruitland, Md.*18. Funeral director *James Stewart*Address *Baltimore, Md.*19. *5/27* *46* *A.W. Zeduck*
(Date rec'd by registrar) (year) (month) (day) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *May 24* 19 *46*, at _____ M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *February 6* 19 *46*, to *May 24* 19 *46*and that I last saw him alive on *May 24* 19 *46*

Immediate cause of death

BRAIN TUMOR; unqualified

DURATION

*2 Mos.*Due to *Could not be determined whether the*
sign or malignant. E.W.B.

Due to _____

Other conditions *Syphilitic Chroiditis**2 Mos.*

(Include pregnancy within 3 months of death)

Major findings of operations *Crainotomy*Date of op. *5-23-46*

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work? _____

23. SIGNATURE *Robert M. Cullison**R.M. CULLISON, M.D. CLIN. MFR.*Address *Ft. Howard, Md.* Date signed *5-25-46*

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 700

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH

County Baltimore
City or town Sparks Pt Road - Edgemere
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County BALTO.
City or town Edgemere - 19
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2812 Webb Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

George F DeArment

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

M

W

married

6.(b) Name of husband or wife Mary Ellen

Mc Cabe

6.(c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) April 13 - 1904

8. AGE: Years 42 Months 1 Days 5 If less than one day
hrs. min.

9. Birthplace Portage, Pa.
(Town, county, and state)

10. Usual occupation Night Supt.

11. Industry or business Rheem Manufacturing Co.

12. Name James F. DeArment

13. Birthplace Pa.

14. Maiden name Unmarried

15. Birthplace Pa.

16. Informant James F. DeArment

Address 2812 Webb Ave.

17. Burial Date thereof May 22 - 46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Sacred Heart

Location Berman Hill Rd.

18. Funeral director John G. Connelly

Address 418 Eastern Ave. Essex

19. May 21 1946 John G. Connelly
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-18-46 19..... at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death
Fractured SKULL
BI-LATERAL FRACTURES
to both FEMURS

Due to Auto Accident

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5-18-46

Where did injury occur? Edgemere BALTO Md
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public Cor.

Means of injury Struck by auto Injured at work? No

23. SIGNATURE

N. J. W. Davis M.D.
Supt. Med. Examiner (Signature)
Address Baltimore Date signed 5/20/46

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md)

CERTIFICATE OF DEATH


 (457140)
 Reg. Dist. No.

1. PLACE OF DEATH:

 County Baltimore
 City or town Kingsville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

 State Md. County Balt
 City or town Kingsville
 (If outside city or town limits, write RURAL and give nearest town)

 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Raymond P. Dilworth

3. (b) Social Security Number

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Mabel C. Dilworth

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

4711

hrs.

min

9. Birthplace

Md.

(Town, county, and state)

10. Usual occupation

Contractor

11. Industry or business

FATHER

12. Name

Howard C. Dilworth

13. Birthplace

Md.

MOTHER

14. Maiden name

Ida Beares

15. Birthplace

Md.

16. Informant

Address

Mabel C. Dilworth
Kingsville Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

May 8 1946
(Date rec'd by registrar)C. E. Arthur
Fork Md.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1946 at 6:15 P. M

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

February 8 1943 to May 6 1946and that I last saw him alive on May 6 1946

Immediate cause of death

Coronary Thrombosis DURATION 15 minHeart Failure with Cystitisand Saccharosis of Sclerotic 2 wksrespiratory & abdominalChronic HypertensionCoronary Atherosclerosis 2 yrs.Heart Disease

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Clifford F. Hudson Date signed 5/8/46

15321

CENTRAL INTELLIGENCE AGENCY

Handwritten notes:
May 14 1946
Mr. J. Edgar Hoover
Director
U.S. Department of Justice
Washington, D.C.
Re: [illegible]
[illegible]
[illegible]

RECEIVED
MAY 18 1946
BUREAU V.S.

Handwritten signature:
Walter D. [illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-2)

CERTIFICATE OF DEATH

C4572

Reg. Dist. No. 40

1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

19. 46, at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 10, 19. 46, to May 22, 19. 46

and that I last saw him alive on May 15, 19. 46

Immediate cause of death

DURATION

Constriction of heart
failure with decompensation
Hypertensive Cardiovascular
Disease
3 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

87
8127

UNITED STATES DEPARTMENT OF JUSTICE

Division of Investigation

MEMORANDUM FOR THE ATTORNEY GENERAL

RE: [illegible]

DATE: [illegible]

ADMINISTRATIVE RECORD

22

ENCLOSURE

11

RECEIVED
MAY 29 1946
BUREAU V.E.

Continued

APPROVED AND FORWARDED

SPECIAL AGENT IN CHARGE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 164-D

CERTIFICATE OF DEATH

04573

★ Reg. Dist. No. 40

1. PLACE OF DEATH: Baltimore
 County Fullerton P.O. Forge Rd.
 City or town (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 53 years
 Hospital, institution, or street address where death occurred:
Forge Road & Cross Road
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Md. County Balto.
 City or town Fullerton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Forge Road & Cross Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME Levise Zastrow Porzbacher

3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced single
 6. (b) Name of husband or wife
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) July 15, 1878
 8. AGE: Years 67 Months 10 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Germany
 (Town, county, and state)
 10. Usual occupation At Home
 11. Industry or business

MOTHER FATHER
 12. Name John Porzbacher
 13. Birthplace Germany
 14. Maiden name Pauline Heaton
 15. Birthplace Germany
 16. Informant Mrs. Simon Butt
 Address Forge Rd. & Cross Rd. Fullerton Md.
 17. burial Date thereof May 30, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Jerusalem Lutheran
 Location Balto., Md.

18. Funeral director Jerusalem Funeral Home
 Address 7401 Belair Road
5/28/46 W. H. Hoffmann
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27, 1946 at 9-P M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____ to _____ 19____
 and that I last saw him _____ alive and _____ 19____
 Immediate cause of death Strangulation by hanging
Subsidiary
 Due to Depression
 Due to Arteriosclerosis & hypertension
 Other conditions _____

DURATION
5/27/46

(Include pregnancy within 3 months of death)
 Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Rolling B. Hudson MD. DNE.
Towson Md
 Address _____ Date signed 5/27/46

RECEIVED

JUN 1 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C4574

Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 Days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Maryland
 How long in hospital or institution? 6 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3608 Clifton Ave.,
 (If rural, give LOCATION)
 2.(a) If veteran, name war WW-I

3.(a) FULL NAME

WILLIAM KIRK DOUGHERTY

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife Single
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) 2-17-1888
 8. AGE: Years 58 Months 2 Days 26 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

FATHER 12. Name Richard A. Dougherty
 13. Birthplace Maryland
 MOTHER 14. Maiden name Arinthia Byrd
 15. Birthplace Maryland

16. Informant Clinical Records, Vets. Adm. Hosp.
 Address Fort Howard, Maryland

17. Burial Date thereof 5-16-44
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Louani Cem.
 Location Windsor Mill Road.

18. Funeral director Order Funeral Home Inc.
 Address 466 44 York Rd H 12.

19. J.R. 46
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13, 1946, at 4:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 7, 1946 to May 13, 1946
 and that I last saw him alive on May 13, 1946

Immediate cause of death
Heart Disease, Coronary
Arteriosclerosis, cardiac enlarge-
ment, myocardial insufficiency

DURATION
Unknown

Due to _____

Other conditions Bronchopneumonia
Bronchitis chronic (From Records)
 (Include pregnancy within 3 months of death)

2 Days

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

SIGNATURE Robert M. Cullison
R.M. CULLISON, M.D. CLIN. DIR.
 Address Ft. Howard, Md. Date signed 5-13-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B-6

CERTIFICATE OF DEATH

Reg. Dist. No. 04575

1. PLACE OF DEATH:

County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 29 yrs., 10 mos., 14 days
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 29 yrs., 10 mos., 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County _____
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 125 Scott Street
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

George Egging

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed
6.(b) Name of husband or wife ?
6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) December 16, 1869
8. AGE: Years 76 Months 5 Days 10 If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual occupation Brass moulder
11. Industry or business Brass
FATHER 12. Name George Egging
13. Birthplace Maryland
MOTHER 14. Maiden name Mary McEntee
15. Birthplace Ireland

16. Informant Hospital records
Address Catonsville-28, Md.
17. Burial Date thereof May 29/46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory New Cathedral
Location 3800 Old Frederick Rd
18. Funeral director Harry D. Wilke
Address 4101 Edmondson Dr.
19. 5/28 46 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1946 at 4:55 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 12 1916 to May 26 1946
and that I last saw him alive on _____ 19____

Immediate cause of death	DURATION
<u>Acute exacerbation</u>	<u>24 hours</u>
Due to <u>Chronic myocarditis</u>	<u>indef.</u>
Due to <u>Old pulmonary tuberculosis of left apex</u>	<u>"</u>
Other conditions <u>Anaemia, extensive of undetermined origin</u>	<u>"</u>
(Include pregnancy within 3 months of death)	

Major findings of operations _____ Date of op. _____
Autopsy results as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____
23. SIGNATURE Isadore Tuerk, M.D. M. D. or other _____
Address Catonsville-28, Md. Date signed 5-27-46

MARGIN RESERVED FOR BINDING

VS A15 9-43-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

CERTIFICATE OF DEATH

04578

Reg. Diat. No. 32

1. PLACE OF DEATH:

County Baltimore
 City or town Brooklandville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Balto.
 City or town Brooklandville
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Anne Preston Emerson

3. (b) Social Security Number

4. Sex

F.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Isaac C Emerson

7. Birth date of deceased (mo., day, yr.)

Jan 28 1872

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

It less than one day

7437hrs.min.

9. Birthplace

New York City
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Wm. R. Preston

FATHER

12. Name

Camden N.Y.

13. Birthplace

Rebecca Dineen

14. Maiden name

MOTHER

15. Birthplace

Evansville Ind.

16. Informant

Fredrick C McCormack

Address

Stevenson Balto & Md

17.

(Burial, cremation, or removal. Which?)

Date thereof

May 7 1946
(month) (day) (year)

Cemetery or crematory

Green Mount

Location

Balto Md

18. Funeral director

Henry M. Jenkins of Am. Co

Address

in Calhoun - Orchard Sts

19.

(Date rec'd by registrar)

5/646A.W. Hedrick

Registar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1946, at 6:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 1945 to May 5 1946and that I last saw him alive on May 3 1946

Immediate cause of death

Cerebral hemorrhage

DURATION

Due to

Apoplexy - severe incident

Due to

to her age

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William A. Bacher

M. D. or other

Address 1115 S. 55th Ave. S.E. Date signed 5/6/46

Dr. Baeyer
1113 St Paul St

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C4577

42

Reg. Dist. No.

1. PLACE OF DEATH

County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 days

Hospital, institution, or street address where death occurred:

1823 Clark Blvd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 1821 North Post St.
(If rural, give LOCATION)2. (a) If veteran, name war none

3. (a) FULL NAME

Johanna Etchberger

3. (b) Social Security Number

217-18-9927

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowedB. (b) Name of husband or wife Ray, Earl Etchberger

7. Birth date of

deceased (mo., day, yr.)

B. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

6120hrs.min.9. Birthplace Baltimore City
(Town, county, and state)10. Usual occupation Supt of Women11. Industry or business Theater Cleaners12. Name Henry Ray13. Birthplace Baltimore14. Maiden name Rebecca Turner15. Birthplace Baltimore16. Informant Mr R F EtchbergerAddress 1823 Clark, Relay Mt17. Burial, cremation, or removal (which) BurialDate thereof 5/6/46
(month) (day) (year)Cemetery or crematorium BaltoLocation " Md.18. Funeral director William Cook Inc.Address 1217 St. Paul St19. 5/4/46

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1946 at 9:40 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 31 1946 to May 2 1946and that I last saw her alive on May 2 1946Immediate cause of death HeartCoronarymetastasisDue to liverBronchopneumoniaDue to (terminal)MyocardialOther conditions pleurisy

(Include pregnancy within 3 months of death)

Major findings of operations noneDate of op. noneAutopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide none Date of none

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R B BrumbloughAddress Elkridge, Md.Date signed 07/1/46

M. D. or other

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B-5

CERTIFICATE OF DEATH

04578

38

Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
 City or town Towson 4, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since Sept 30, 1935
 Hospital, institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Md.
 How long in hospital or institution? Since Sept 30, 1935

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County
 City or town Baltimore City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 318 - South Wolfe St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war. ✓

3. (a) FULL NAME

FUNK, ANNIE MARTHA.

3. (b) Social Security Number

4. Sex F 5. Color or race W. 6. (a) Single, married, widowed, or divorced WIDOWED
 6. (b) Name of husband or wife Vernon Clark Funk
 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) June 18, 1892
 8. AGE: Years 53 Months 10 Days 23 If less than one day hrs. min.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1946 at 11 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 30 1935 to May 10 1946
 and that I last saw her alive on May 10 1946

Immediate cause of death Pulmonary tuberculosis DURATION Since 1931
 Due to
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE W A Bridges M. D. or other
 Address Towson 4, Maryland Date signed 5-10-46

9. Birthplace Maryland (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business own Home
 12. Name Thomas Parks
 13. Birthplace Maryland
 14. Maiden name Emily Ennis
 15. Birthplace Maryland

Personal History- Hospital Records

16. Informant Eudowood Sanatorium, Towson 4, Md.
 Address Burial Date thereof 5/13/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Moreland Park
 Location Parkville Md.
 18. Funeral director William Cook Inc
 Address 1217 St. Paul St.
 19. 5/13 1946 A.W. Hedrick
 (Date rec'd by registrar) Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
 CERTIFICATE OF DEATH 23

Registered No. 04564

1. PLACE OF DEATH:

(a) Baltimore, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

male

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

Hattie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 78 Months 9 Days 24 If less than one day hr. min.

9. Birthplace

Sandy Spring, Md.

10. Usual Occupation

11. Industry or business

FATHER

12. Name

Samuel Gardman

13. Birthplace

Howard Co. Md.

14. Maiden Name

Julia Strong

15. Birthplace

Montgomery Co. Md.

16 (a) Informant

Mrs. Hattie C. Gardman

(b) Address

Bare Hill, Falls Rd.

17 (a)

Burial (b) Date thereof May 30, 1946

(c) Cemetery or crematory

St. Johns

Location

Ruxton, Md.

18 (a) Funeral director

Mrs. George W. Holland

(b) Address

1631 Druid Hill Ave

19 (a)

Date rec'd by registrar

30 1946

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md. (b) County

(c) City or town

Baltimore

(d) Street No.

Bare Hills, Falls Rd.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 27, 1946, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 20, 1946, to May 27, 1946, and that I last saw him alive on May 27, 1946.

Immediate cause of death

Cerebral Hemorrhage

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 2529 Guep St

Date signed

30 1946

PHYSICIAN

Underline the cause to which death should be charged statistically.

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE

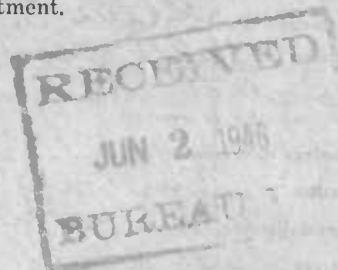
cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see **PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION** issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04579

Reg. Dist. No. 41

1. PLACE OF DEATH:

County Baltimore

City or town Sundalk
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 weeks

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Sundalk
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1815 Maxwell Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

JULIA P. GATTON.

3. (b) Social Security Number

none

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Vonder G. Gatton

7. Birth date of deceased (mo., day, yr.) March - 3rd. 1888

6. (c) If alive, give age years

8. AGE: Years 58 Months 2 Days 28 If less than one day hrs. min.

9. Birthplace St. Marys Co. - Md.
(Town, county, and state)

10. Usual occupation House Work -

11. Industry or business at home

12. Name Frederick Magill

13. Birthplace Md.

14. Maiden name Amanda Goldsborough

15. Birthplace Md.

16. Informant Mrs. Linda Legere

Address 1815 Maxwell Ave

17. Burial Date thereof June - 3 - 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Meadow Ridge Cemetery

Location Charles J. Schupb.

18. Funeral director 505 N. Monroe St.

Address 613 46 Capital

19. (Date rec'd by registrar) 6/3/46 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-31- 19 46 at VP M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-27 19 45 to 5-31 19 46
and that I last saw her alive on 5-31- 19 46

Immediate cause of death myocardial degeneration

Due to Carcinoma of gall bladder

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE David Miller MD M. D. or other

Address 1500 N Bldway Date signed 6/1/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 Days

Hospital, institution, or street address where death occurred:
Remind an

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2925 Winchester St.,
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

M. Katherine Gibson

3.(b) Social Security Number
none

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 28, 1862

8. AGE: Years 83 Months 9 Days 26 It less than one day
..... hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Retired School Teacher

11. Industry or business Baltimore City

12. Name Joseph Gibson

13. Birthplace Ireland

14. Maiden name Margaret Fusselbaugh

15. Birthplace Md.

16. Informant Mrs. Agnes H. Gibson

Address 2925 Winchester St.,

17. Burial Date thereof 5-27-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baltimore

Location Baltimore, Md.

18. Funeral director G. Howard Strong

Address 3207 W. North Ave.,

19. 5/27/46 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24, 1946 at 2:15 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
..... 19....., to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death..... DURATION

Acute cardiac failure

Due to Cardiovascular disease

Due to accident fractured leg

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Accident Date of May 10, 46

Accident, suicide, or homicide

Where did injury occur? Baltimore City (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Fall down stairway Injured at work? no

G. M. Kieffer M. D. or other

23. SIGNATURE G. M. Kieffer

Address 1010 Lehigh Date signed 5/28/46

MARGIN RESERVED FOR BINDING

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 920

CERTIFICATE OF DEATH

C4581

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 60 Years
 Hospital, institution, or street address where death occurred:
9 Bishop's Lane
 How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Baltimore Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 9 Bishop's Lane
 (If rural, give LOCATION)

 2(a) if veteran, name war -----

3. (a) FULL NAME

Christine Elizabeth Graber

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Peter S. Graber
 6. (c) If alive, give age --- years
 7. Birth date of deceased (mo., day, yr.) December 24, 1865
 8. AGE: Years 80 Months 5 Days 5 If less than one day --- hrs. --- min.

9. Birthplace Frederick, Md.
 (Town, county, and state)
 10. Usual occupation None
 11. Industry or business -----
 12. Name Peter Haydock
 13. Birthplace Austria
 14. Maiden name ----- Miller
 15. Birthplace Germany

16. Informant Rosina E. Graber
 Address 9 Bishop's Lane, Catonsville

17. Burial Burial Date thereof 6/1/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory New Cathedral
Baltimore, Md.
 Location W. W. Meeks and Son

16. Funeral director W. W. Meeks and Son
 Address 805 N. Calvert Street

19. 6-1 1946 Harry L. Miller
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 May 19 46, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 29 May 19 46, to 29 May 19 46, and that I last saw him alive on 29 May 19 46.

Immediate cause of death ventricular failure DURATION 1 hr

Due to Chronic myocarditis Unknown
 Due to Arteriosclerosis Unknown

Other conditions -----
 (Include pregnancy within 8 months of death)

Major findings of operations ----- Date of op. -----

Autopsy results -----
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide ----- Date of -----
 Where did injury occur? ----- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----
 Means of injury ----- Injured at work? -----

23. SIGNATURE Stephen Lee Magness MD M. D. or other -----
 Address 752 Frederick Ave Date signed 31 May

RECEIVED
JUN 4 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH
& birth date of deceased is shown 2411 N. Charles St., Baltimore (82-a)
on
FILM No. I O 4 MAY 22 1946 CERTIFICATE OF DEATH

04582 38
Reg. Dist. No.

1. PLACE OF DEATH: Baltimore
County Towson
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 years
Hospital, institution, or street address where death occurred:
610 York Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. 610 York Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Henry Milton Gray

3. (b) Social Security Number
214-24-3767

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Mabel Clare Gray
8. (c) If alive, give age 50 years
7. Birth date of deceased (mo., day, yr.) Jan. 3, 1892 1891
8. AGE: Years 54 Months 55 Days 4 If less than one day 17 hrs. - min.

9. Birthplace Baltimore Co., Maryland
(Town, county, and state)
10. Usual occupation Maintenance Man
11. Industry or business Black & Decker Mfg. Co.
12. Name Robert Henry Gray
13. Birthplace Virginia
14. Maiden name Harriett B. Dudrow
15. Birthplace Ohio

16. Informant Mrs. H. Milton Gray
Address 610 York Rd., Towson, Md.
17. Burial Date thereof May 23rd 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Louisa Park Cem.
Location Baltimore Md.
18. Funeral director John Burrie Soap
Address Towson, Md.
19. 5/21 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20, 1946 at 3:45 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
1838 to 20 May 1946
and that I last saw him alive on 19 May 1946

Immediate cause of death Cerebral Hemorrhage
Due to Hypertension
Due to
Other conditions
(Include pregnancy within 3 months of death)

DURATION
6 hrs.
Byrs.

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE Robert H. Allison M.D.
M. D. or other
Address 4 Burkleigh Sq. Towson, Md. Date signed 20 May 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1865)

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Balto
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 yrs 6 mos
 Hospital, institution, or street address where death occurred Spring Grove State Hosp
 How long in hospital or institution? 4 yrs 6 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Baltimore
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2304 Aiken st
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

Christine Green

3. (b) Social Security Number

none

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

George Green

7. Birth date of deceased (mo., day, yr.)

Oct. 24, 1884

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

8169hrs.min.

9. Birthplace

Balto md
(Town, county, and state)

10. Usual occupation

unemployed

11. Industry or business

House wife

FATHER

12. Name

Adam Hildreth

13. Birthplace

Germany

14. Maiden name

Anna Hoffman

15. Birthplace

Germany

16. Informant

Address

Hospital record

17.

(Burial, cremation, or removal, Which?)

Date thereof

May 16/46
(month) (day) (year)

Cemetery or crematory

Wt. Laurel

Location

BALTIMORE

18. Funeral director

Address

Philip's Funeral Home
2014 Calhoun St

19.

(If recorded by registrar)

Registrar

5/16/46
Andrew

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 13, 1946 at 6:45 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19and that I last saw him alive on 19

Immediate cause of death

DURATION

Broncho Pneumonia

Due to

fractured left hip

Due to

sudden death

Other conditions

Injury

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. May 13/46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of April 23, 46Where did injury occur? Catonsville Balto md
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HospitalMeans of injury pushed from back bench
by another patient injured at work? no

23. SIGNATURE

Dr. W. KiefferM. D. or other Physician

Address

1010 Leeds AveDate signed 5-3-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B-1

04584

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County Baltimore
 City or town Mount Wilson
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 yrs. 1 mo., 16 days
 Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
 How long in hospital or institution? 5 yrs., 1 mo., 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3600 White Avenue
 (If rural, give LOCATION)
 2(a) If veteran, name war _____

3. (a) FULL NAME

Mr. Marion Grimes

3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Mrs. Mable R. Grimes
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) September 2, 1889
 8. AGE: Years 56 Months 8 Days 3 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)
 10. Usual occupation Chauffeur
 11. Industry or business _____
 12. Name Louis N. Grimes
 13. Birthplace Patapsco, Maryland
 14. Maiden name Laurabelle Simmons
 15. Birthplace Baltimore, Maryland

16. Informant Mr. Marion Grimes
 Address 3600 White Ave., Balto., Md.
 17. Burial May 8, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Glen Haven Cemetery
 Location Anne Arundel Co., Maryland
 18. Funeral director William Cook, Inc.
 Address 1217 St. Paul St., Balto., Md.
 19. May 5, 1946 Earl T. Webster
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5, 1946 at 12:00 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19, 1941 to May 5, 1946
 and that I last saw him alive on May 5, 1946

Immediate cause of death Pulmonary Tuberculosis DURATION 9 yrs.

Due to Tubercle Bacilli

Due to _____

Other conditions Oil Pneumonia 1 Wk.

(Include pregnancy within 3 months of death)

Major findings of operations No operation

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

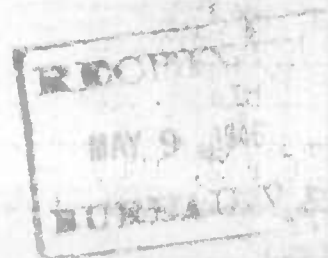
23. SIGNATURE Stewart S. Shaffer M.D. M.D. or other _____Address Mount Wilson, Md. Date signed 5/5/46

MARGIN RESERVED FOR BINDING

VS A15 19-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Rec'd - 5-8-46 Dr. E. E. Nichols



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

32
2698

1. PLACE OF DEATH:

County Baltimore Co.
City or town Pikesville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Scotts Lane + Milford Rd
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 45 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore Co.
City or town Pikesville and Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Scotts Lane + Milford Rd
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR none

3. (a) FULL NAME

John Wendell Grinage

3. (b) Social Security Number

none

4. Sex Male 5. Color or race colored 6. (a) Single, married, widowed, or divorced married
6 (b) Name of husband or wife Mrs. Lourena Grinage
6 (c) If alive, give age 51 years
7. Birth date of deceased (mo., day, yr.) March 28 1893
8. AGE: Years 53 Months Days If less than one day hrs. min.

9. Birthplace Washington, D.C. (Town, county, and state)
10. Usual occupation School teacher
11. Industry or business Baltimore Public School No. 117
12. Name John F. Grinage
13. Birthplace Maryland
14. Maiden name Miss Ruth Thomas
15. Birthplace Maryland

16. Informant Mrs. Lourena Grinage
Address Pikesville Md
17. Burial Date thereof May 29 1946
(Burial, cremation, or removal) (month) (day) (year)
Cemetery or crematory Mt. Auburn
Location Baltimore, Maryland
18. Funeral director Mrs. George H. Holland
Address 1631 Druid Hill Ave.

19. 5/29/46 19 46
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-25-1946 at 6 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-1-1946 to 5-25-1946
and that I last saw him alive on 5-24-1946

Immediate cause of death

myocarditis

DURATION

2 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank A. Saunders MD M. D. or other
Address 1029 N. Stricker St. Date signed 5-26-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

md. State Dept of Health
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1952

Registered No.

32

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

(b)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 27, 1946, at 8 A M

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to death on the day stated above, and death in my

opinion resulted from: natural causes ☐, accident ☐, suicide ☐,homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Internal hemorrhage
Lacerated lungs

Due to Accident undetermined

Other Conditions

Fractured ribs,
Lacerations and crush burns
(Include pregnancy within 3 months of death)22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

Found Lane off Liberty Road below

(b) Where did injury occur?

Park Hill town, Md.

(c) Did injury occur at home, on farm, industrial place, in public

place?

public

While at work?

(d) Means of injury

23. Signature

M.D.

Date signed

5-28-46

Medical Examiner

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH

County Baltimore
 City or town Towson, Pulasky Rd. Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 1/2 days, auto collision
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town 32 Northwood Drive
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Timonium
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Robert Orrin

3. (b) Social Security Number

Hall

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Sarah Hinton Hall6. (c) If alive, give age 29 years

7. Birth date of

deceased (mo., day, yr.) February 3, 1914

8. AGE:

Years

32

Months

3

Days

23

If less than one day

hrs. min.

9. Birthplace Monks, N.Y.

(Town, county, and state)

10. Usual occupation Insurance Agent11. Industry or business Wash. Natl. Ins. Co.12. Name Fred W. Hall13. Birthplace Providence, R.I.14. Maiden name Lillian Mills15. Birthplace Burlington, Wis.16. Informant Mrs. Sarah H. HallAddress 32 Northwood Drive, Timonium, Md.

17. Removal

(Burial, cremation, or removal, Which?)

Date thereof May 28, 1946
(month) (day) (year)Cemetery or crematory Frank E. RemingtonLocation 1604 Broad St. Providence, R.I.

18. Funeral director

Address Towson, Maryland19. May 28 19 46
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 19 46 at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 19Immediate cause of death Fractured skullcompounded; cerebral concussion 5/26/46Fractured neck, cervico-thoracic junction 5/26/46Due to Auto Accident 5/26/46

Due to

Other conditions Deep lacerations thigh muscles 5/26/46

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 5/26/46Where did injury occur? Towson Baltimore Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Public highway, Pulasky Rd.Means of injury Auto accident collision Injured at work? No

23. SIGNATURE

Bollin F. Hudson Md D.M.E.
Address Towson 4, Md. Date signed 5/26/46

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

REC'D

JUN 2 1946

BUREAU V. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04587 ✓✓

1. PLACE OF DEATH:
 County... Fort Howard, Md.
 City or town... Fort Howard, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Veteran's Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State... Maryland County...
 City or town... Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3502 Keene Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME
Thomas F. HAND.

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Margaret Catherine

7. Birth date of deceased (mo., day, yr.) June 7, 1874 6. (c) If alive, give age years

8. AGE: Years 71 Months 11 Days 24 If less than one day hrs. min.

9. Birthplace Baltimore CO., Md.
 (Town, county, and state)

10. Usual occupation retired

11. Industry or business

12. Name ?
 13. Birthplace ?

14. Maiden name ?
 15. Birthplace ?

16. Informant Mrs. M. Catherine Hand
 Address 3502 Keene Avenue 14

17. Burial 5/14/46
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
 Cemetery or crematory Baltimore National
 Location Baltimore

18. Funeral director Leonard J. Ruck
 Address 5305 Harford Road 14

19. 5/13 45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/11/46 19 at 1:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/11/46 19 to 5/11/46 19
 and that I last saw him alive on 5/11/46 19

Immediate cause of death Hypernephroma
right kidney, with
metastasis
 Due to 6 mos

Other conditions Coronary arteriosclerosis
heart disease
 (Include pregnancy within 8 months of death)

Major findings of operations. Date of op.

Autopsy results. PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Leonard J. Ruck M. D. or other
 Address Baltimore, Md. Date signed 5/14/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 87a

CERTIFICATE OF DEATH

Reg. Dist. No.

4588 40

1. PLACE OF DEATH.

County BaltoCity or town Fallston
(If outside city or town limit, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltoCity or town Fallston
(If outside city or town limit, write RURAL and give nearest town)Street No. ✓
(If rural, give LOCATION)2.(a) If veteran, name war ✓

3. (a) FULL NAME

James T. Haulon

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

✓

6. (b) Name of husband or wife

8. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

Sept 28, 1945

8. AGE:

Years

Months

Days

If less than one day

_____ hrs. _____ min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Thomas J. Haulon13. Birthplace Md.14. Maiden name Marquet Cain15. Birthplace Md.16. Informant Mr. Thos HaulonAddress Fallston Md17. Buried Date thereof May 18, 1946
(Burial, cremation or other, Which?) (month) (day) (year)Cemetery or crematory St. JohnsLocation Wood Green Rd.18. Funeral director Chas. E. GossAddress Benson Md.19. May 18 19 46 G. E. Arthur
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16, 1946, at 5:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6, 1946 to May 16, 1946 and that I last saw her alive on May 14, 1946Immediate cause of death Bilateral Otitis Media DURATION 6 daysDue to Upper Respiratory Infection 12 daysDue to General Debility

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

Signature Clifford J. Hudson, M.D. M. D. or other _____Address Fallston Md. Date signed 5/18/46

RECEIVED
MAY 24 1945
BUREAU OF

Evidence for the change of

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH BALTIMORE County BALTIMORE Registration Dist. No. 38
 Village or City RIDERWOOD No. 832 St. 4589 Ward 38
 Length of residence in city or town where death occurred 38 yrs. How long in U.S. if of foreign birth? 38 yrs. mos. 38 ds.

2. FULL NAME ELIA MCHALE HARRINGTON If U. S. Veteran, specify WAR WAR
 (a) Residence: No. SAME St. SAME Ward. SAME
 (Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS				MEDICAL CERTIFICATE OF DEATH	
3. SEX <u>F</u>	4. COLOR OR RACE <u>WHITE</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>MARRIED</u>		21. DATE OF DEATH <u>May</u> <u>21</u> , 19 <u>46</u> (Month) (Day) (Year)	
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of <u>THOMAS G. HARRINGTON</u>				22. I HEREBY CERTIFY, That I attended deceased from <u>Apr 10</u> , 19 <u>46</u> , to <u>May 21</u> , 19 <u>46</u>	
6. DATE OF BIRTH (month, day, and year) <u>April 13 1867</u>				I last saw her alive on <u>May 20</u> , 19 <u>46</u> ; death is said to have occurred on the date stated above, at <u>100</u> A.M.	
7. AGE <u>About 78</u> yrs.	Years	Months	Days	The PRINCIPAL CAUSE OF DEATH and related causes of Importance were as follows:	
8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BODDKEEPER, etc. <u>HOUSEWIFE</u>				Broncho pneumonia, terminal Cerebral hemorrhage, E. R. hemi- plegia, & aphasia Hypertension Other Contributory Causes of Importance:	
9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. <u>OWN HOME</u>					
10. Date deceased last worked at this occupation (month and year)				Date of onset <u>5 weeks</u> <u>1946</u> <u>week</u>	
11. Total time (years) spent in this occupation					
12. BIRTHPLACE (city or town) (State or country) <u>West Virginia</u>					
13. NAME <u>PATRICK MCHALE</u>					
14. BIRTHPLACE (city or town) (State or country) <u>West Virginia</u>					
15. MAIDEN NAME <u>MARY MAHEY</u>					
16. BIRTHPLACE (city or town) (State or country) <u>West Virginia</u>					
17. INFORMANT <u>Thos. G. HARRINGTON</u>					
18. BURIAL, CREMATION, OR REMOVAL <u>Monteagle</u> Date <u>5 28</u> , 19 <u>46</u>					
19. UNDERTAKER (Address) <u>3102 N. Charles St.</u>					
20. FILED <u>May 21</u> , 19 <u>46</u> Registrar <u>Benjamin A. Allen</u> M. D. (Address) <u>Leithersville, Md.</u>					

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 191-5

CERTIFICATE OF DEATH

04590

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
City or town CATONSVILLE
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 11111n Choice Lane

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL NEAR and give town) Ward No.

Street No. 11111n Choice Lane
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

Amanda Harvey

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

87

Not Known

hrs.

min.

9. Birthplace

Baltimore, Md
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Daughter of the Deceased
11111n Choice Lane

Address

17.

Burial

Date thereof

May 26-46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Cathedral

Location

Baltimore

18. Funeral director

Rita Friedefeld

Address

900 E Biddle St Baltimore MD

19.

5-18-

1946

Harold Miller
Registrar

Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 16

19 46, at 4:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb

19 47, to

May 16

19 46

and that I last saw him alive on

May 11

19 46

Immediate cause of death

Stroke of the Aorta

Due to

Due to

Other conditions

Chronic Nephritis

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Amanda Harvey
Catonsville 28-MD

M. D. or other

Date signed 5/18/46

MARGIN RESERVED FOR BINDING

VSA15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 20 1946

BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County 7807 Wilson AveCity or town Parkville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. CountyCity or town Parkville
(If outside city or town limits, write RURAL and give nearest town)Street No. 7807 Wilson Ave
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Eurith E. Hays

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced married8.(b) Name of husband or wife Edgar W. Hays7. Birth date of deceased (mo., day, yr.) July 7, 1906 6.(c) If alive, give age 39 years8. AGE: Years 39 Months 10 Days 18 If less than one day _____ hrs. _____ min.9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name John R. Osborn13. Birthplace Md.14. Maiden name Lelia Greenfield15. Birthplace Md.16. Informant Mr. Edgar W. HaysAddress 7807 Wilson Ave. Parkville17. Burial Date thereof 5/28/46
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory ParkwoodLocation Taylor Ave18. Funeral director Howard W. Blight Jr.Address 6009 Bayview Road19. 5/28/46 by registrar (Date) (Month) (Day) (Year)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1946, at 3 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1945 to May 25 1946
and that I last saw her alive on May 19 1946Immediate cause of death Cardiac failure DURATIONDue to Rheumatic Valvular DiseaseDue to Rheumatic feverOther conditions Dementia praecox

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thomas Brennan M. D. or otherAddress 5217 Harford Road Date signed May 25, 1946

STATE OF MARYLAND—CERTIFICATE OF DEATH

1593

1. PLACE OF DEATH

County Balto Registration Dist. No. 40
 Village or City Fork P.O. St. _____ Ward _____
 Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. (If death occurred in a hospital or institution, give its NAME instead of street and number)
 How long in U.S. If of foreign birth? _____ yrs. _____ mos. _____ ds.

2. FULL NAME

Evelyn Henneay
 (a) Residence: No. _____ St. _____ Ward _____
 (Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6. DATE OF BIRTH (month, day, and year) Sept 27 - 1868

7. AGE Years 77 Months 7 Days _____ If LESS than 1 day _____ hrs. _____ min.

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BDDKEEPER, etc. _____
 9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. _____
 10. Data deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (city or town) md
 (State or country)

13. NAME William Henneay
 14. BIRTHPLACE (city or town) Ireland
 (State or country)

15. MAIDEN NAME Ann Devaney
 16. BIRTHPLACE (city or town) Ireland
 (State or country)

17. INFORMANT James Henneay
 (Address) 120 S. E. Ave

18. BURIAL, CREMATION, OR REMOVAL
 Place New Cathedral Date _____, 19____

19. UNDERTAKER Clarence E. Arthur
 (Address) Fork P.O.

20. FILED May 18, 1946 C. E. Arthur
 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH May 18, 1946
 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
 I last saw him _____ alive on _____, 19____; death is said to have occurred on the date stated above, at _____ m.
 The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Coronary occlusion
 Date of onset March 18

Other Contributory Causes of importance: _____
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (VIOLENCE) fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county and State)
 Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify Arteriosclerosis
 (Signed) Deputy Medical Examiner M. D.
 (Address) Baltimore, Md.

MARGIN RESERVED FOR BINDING

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927
Other contributory causes of importance:	
Gallstones	May 1, 1923

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	1 week ago
Run over by street car	1 week ago
Peritonitis	3 days ago
Other contributory causes of importance:	
Gastroenteritis	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

14592

Reg. Dist. No. 38

1. PLACE OF DEATH:
County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
405 Central Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. 405 Central Avenue
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME John Seng Held

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
B. (b) Name of husband or wife Bessie Hook Held
7. Birth date of deceased (mo., day, yr.) September 18, 1883 8. (c) If alive, give age 63 years
8. AGE: Years 62 Months 7 Days 29 If less than one day — hrs. — min.

9. Birthplace Towson, Balto. Co., Maryland
(Town, county, and state)

10. Usual occupation Court Librarian

11. Industry or business Circuit Court, Balto. Co.

12. Name Lewis W. Held

13. Birthplace Germany

14. Maiden name Fredericka Breyer

15. Birthplace Germany

16. Informant Mrs. John S. Held

Address 405 Central Ave., Towson 4, Md.

17. Burial Date thereof May 19, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Prospect Hill Cemetery

Location Towson, Maryland

18. Funeral director John Burns' Sons

Address Towson, Maryland

19. May 19, 1946 (Date rec'd by registrar) Deputy State Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH May 16, 1946 at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 14, 1946 to May 16, 1946 and that I last saw him alive on May 16, 1946

Immediate cause of death

Coronary Thrombosis

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Daniel W. Thompson M. D. or other

Address Towson, Md. Date signed 5/18/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 2 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Balto.
 City or town Catonville add.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 mos
 Hospital, institution, or street address where death occurred:
5501 Edmondson ave
 How long in hospital or institution? during home 6 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Balto.
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1306 Northview Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

Mag Delene Hester

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced widow
 6.(b) Name of husband or wife G. Lewis Hester
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Sept 10. 1877
 8. AGE: Years 68 Months 8 Days 13 It less than one day _____ hrs. _____ min.

9. Birthplace Germany
 (Town, county and state)

10. Usual occupation retired

11. Industry or business _____

12. Name Carl Delmann

13. Birthplace Germany

14. Maiden name Emma Baumann

15. Birthplace Germany

16. Informant Gao. H. Hester

Address 1306 Northview Road

17. Burial Date thereof May 25/46
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Woodlawn

Location " Md.

18. Funeral director John O. Mitchell & Sons

Address 1400 Eutaw Place

5/24 1946 A. W. H. Hester
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1946 at 7:45 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 17 1945, to May 23 1946

and that I last saw him alive on May 23 1946

Immediate cause of death Cerebral Hemorrhage DURATION 1 wk

Due to Cerebral Arterio Sclerosis

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE James H. Hester M. D. or other _____

Address Catonville Date signed 5/23

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30-11

04595

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
City or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 22 days

Hospital, institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? 4 months, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 719 St. Paul Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Harry E. Hincy

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male

white

widowed

6. (b) Name of husband or wife Valeria Los

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21, 19058. AGE: Years Months Days If less than one day
40 10 16 hrs. min.9. Birthplace Stark County, Ohio
(Town, county, and state)10. Usual occupation Salesman11. Industry or business Liquor12. Name William C. Hincy13. Birthplace Pennsylvania14. Maiden name Katherine Davis15. Birthplace ?16. Informant Hospital recordsAddress Catonsville-28, Md.17. Burial
(Burial, cremation, or removal. Which?)Date thereof May 10-46
(month) (day) (year)

Cemetery or crematory

Location Pittsburg, Pa.18. Funeral director Robert Brooks + SonAddress Calhoun & Hallins Street19. 5-8-46
(Signature of registrar)

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH May 7 19 46 at 5:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 15 19 45 to May 7 19 46and that I last saw him alive on May 7 19 46

Immediate cause of death

General paresis (syphilis)

DURATION

IndefiniteDue to Therapeutic malaria20 days

Due to

Other conditions Aortitis (luetic?)Indefinite

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Isadore Tuerk, M.D.

M. D. or other

Address Catonsville-28, Md. Date signed 5-7-46

MARGIN RESERVED FOR BINDING

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9-45-15M

VS A15

AT

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

04596

Reg. Dist. No.

1. PLACE OF DEATH: BALTIMORE
 County.....
 City or town.....CHESTNUT RIDGE
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long to hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....MD County.....BALTO
 City or town.....CHESTNUT RIDGE
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....GREENSPRING AVE
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....LUTHERVILLE P.O.

3. (a) FULL NAME

JOSEPHINE HOFFMAN

3. (b) Social Security Number

4. Sex.....FEM
 5. Color or race.....WHITE
 6.(a) Single, married, widowed, or divorced.....SINGLE

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....DECEMBER 17-1866
 6.(c) If alive, give age..... years

8. AGE: Years.....79 Months.....4 Days.....17
 If less than one day..... hrs. min.

9. Birthplace.....BALTIMORE Co MD
 (Town, county, and state)

10. Usual occupation.....NONE

11. Industry or business.....

FATHER 12. Name.....GEORGE HOFFMAN
 13. Birthplace.....GERMANY

MOTHER 14. Maiden name.....MARGARET HETRICK
 15. Birthplace.....GERMANY

16. Informant.....MRS CHARLES FORWARD
 Address.....GREENSPRING AVE LUTHERVILLE P.O.

17. BURIAL Date thereof.....MAY. 6-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....HOLY CROSS
 Location.....A.A.Co.

18. Funeral director.....Bernard B. Harle
 Address.....131 E. West St

19. 5/8/46 (Date rec'd by registrar)
 Registrar.....

MEDICAL CERTIFICATION

20. DATE OF DEATH.....MAY. 4th 19..46 at 3:20 A M

21. I CERTIFY that death occurred on the date above stated; that I am a Married deceased from
3-7-46 to 5/4/46
 and that I last saw her alive on 5/3/46 19..46

Immediate cause of death.....myocarditis
chronic - decompensating

Due to.....hypertension
 Due to.....arteriosclerosis

Other conditions.....☒

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....James L. Saffell
Resident Physician, Md. M. D. or other
 Address.....5/3/46 Date signed.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 33

04597

1. PLACE OF DEATH: County <u>Balto.</u> City or town <u>Owings Mills</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>18 yrs</u> Hospital, institution, or street address where death occurred: _____ How long in hospital or institution? _____				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Md.</u> County <u>Balto.</u> City or town <u>Owings Mills</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>Pleasant Hill Park</u> (If rural, give LOCATION) <u>None</u> 2.(a) If veteran, name war _____			
3.(a) FULL NAME <u>Ada Jeanette Holland</u>				3.(b) Social Security Number <u>None</u>			
4. Sex <u>Female</u>		5. Color or race <u>White</u>		6.(a) Single, married, widowed, or divorced <u>Married</u>			
6.(b) Name of husband or wife <u>Walter S. Holland</u>				6.(c) If alive, give age _____ years			
7. Birth date of deceased (mo., day, yr.) <u>May 12, 1884</u>				8. AGE: Years <u>62</u> Months _____ Days <u>1</u> If less than one day _____ hrs. _____ min.			
9. Birthplace <u>Balto.Co.</u> (Town, county, and state)				10. Usual occupation <u>Housework</u>			
11. Industry or business _____				12. Name <u>Cyrus G. Gover</u>			
13. Birthplace <u>Carroll Co.</u>				14. Maiden name <u>Mary Poole</u>			
15. Birthplace <u>Md.</u>				16. Informant <u>Lillian Smith</u> Address <u>Owings Mills</u>			
17. Burial (Burial, cremation, or removal. Which?) <u>Burial</u> Date thereof <u>May 17, 1946</u> (month) (day) (year) Cemetery or crematory <u>Reisterstown Methodist</u> Location <u>Balto.Cc.</u>				18. Funeral director <u>J.F.Eline & Sons</u> Address <u>Reisterstown, Md.</u>			
19. <u>5-16</u> <u>1946</u> (Date rec'd by registrar)				20. DATE OF DEATH <u>5-13-46</u> 19____ at <u>3:30 P.</u> M			
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>5-14-46</u> 19____ to <u>5-14-46</u> 19____ and that I last saw him <u>not seen alive</u> 19____				Immediate cause of death <u>Cerebral Hemorrhage</u> DURATION <u>1 hr.</u>			
Due to _____				Due to _____			
Other conditions _____				(Include pregnancy within 3 months of death)			
Major findings of operations _____				Date of op. _____			
Autopsy results _____				PHYSICIAN: Please underline the cause to which death should be charged statistically.			
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide _____ Date of _____				Where did injury occur? _____ (City or town) _____ (County) _____ (State)			
Injured at home, farm, industry, public place (where?) _____				Means of injury _____ Injured at work? _____			
23. SIGNATURE <u>J.D. Caplan, M.D.</u> <u>exam</u> M. D. or other _____				Address <u>Reisterstown, Maryland</u> Date signed <u>5-14-46</u>			
19. <u>5-16</u> <u>1946</u> (Date rec'd by registrar)				20. <u>Mary B. Eline</u> Registrar			

MAY 20 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 136

CERTIFICATE OF DEATH

Reg. Dist. No. 04598 44

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 27 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, Md.How long in hospital or institution? 27 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 1428 Druid Hill Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war WW-I

3. (a) FULL NAME

FLETCHER HOLMES

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Clara Holmes6. (c) If alive, give age 35 years7. Birth date of deceased (mo., day, yr.) August 1, 1898

8. AGE:

Years

Months

Days

If less than one day

47927

hrs.

min.

9. Birthplace South Carolina

(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

12. Name Peter Holmes13. Birthplace South Carolina14. Maiden name Fannie Pope15. Birthplace South Carolina16. Informant Clinical Records, Vets. Adm. Hosp.

Address

Ft. Howard, Maryland17. Burial Date thereof 6/3/46
(Burial, cremation, or removal) Which? (month) (day) (year)Cemetery or crematory Baltimore NationalLocation Elroy O. Wilson

18. Funeral director

Address

1000 Brantley Ave. Balto. Md.19. June 1 19 46 A. W. Hedrich
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28, 1946 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1, 1946 to May 28, 1946and that I last saw him alive on May 28, 1946

Immediate cause of death

PULMONARY TUBERCULOSIS, ACTIVE 4

DURATION

Unknown

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Same as Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

F. J. Ryan, M.D., COL. M.C.
Ft. Howard, Md. 5-28-46 IN.
Date signed

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 44599 42

1. PLACE OF DEATH:

County BaltimoreCity or town Relay

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

4937 Cedar Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Relay

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4937 Cedar Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Mary F. Horermill

3. (b) Social Security Number

4. Sex Female5. Color or race white

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Averill L.7. Birth date of deceased (mo., day, yr.) July 13, 1865

8. (c) If alive, give age.....years

8. AGE: Years 80 Months 10 Days 1 If less than one day

.....hrs.min.

9. Birthplace West Virginia

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Isaac Largent13. Birthplace Virginia14. Maiden name Sarah A. Allender15. Birthplace Virginia16. Informant Mrs W. V. WidmeyerAddress 4937 Cedar Ave.17. Burial Date thereof May 17, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory GreenwayLocation Berkeley Springs West. Virginia18. Funeral director Harry H. WitkeAddress 4101 E. Diamond Ave.19. May 16 19 46 Geo Kieffer

(Date rec'd. by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 19 46 at 8:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 19 46, to May 14 19 46;and that I last saw her alive on May 13 19 46;Immediate cause of death Myocardialinfarction (pulmonary)edemaDURATION 3 dayDue to bronchitis &hypertensionDue to arteriosclerosishigh blood pressure

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Geo. KiefferAddress 9868 Harford Date signed 5/15/46

M. D. or other

1010

See

RECEIVED
MAY 21 1946
BUREAU VE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04600 37

1. PLACE OF DEATH:

County Baltimore
 City or town Cockeysville Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 yrs
 Hospital, institution, or street address where death occurred:
Masonic Home, Cockeysville Md.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Baltimore
 City or town Baltimore Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3118 Windsor Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mrs Mollie C. Hutchinson

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced—Widow
 8.(b) Name of husband or wife Frank P. Hutchinson 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Dec. 11 - 1865
 8. AGE: Years 80 Months 4 Days 23 If less than one day _____ hrs. _____ min.

9. Birthplace Seaford, Delaware
 (Town, county, and state)
 10. Usual occupation Housewife

11. Industry or business

12. Name James R. Marvel
 13. Birthplace Georgetown Delaware
 14. Maiden name Melinda Colborn
 15. Birthplace Seaford, Delaware

16. Informant Laura M. Schroeder
 Address Masonic Home, Cockeysville Md

17. Burial Date thereof May 8 - 46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Olaf
 Location Frederick Rd

18. Funeral director Geo. J. Buss Jr.
 Address 1512 Hollins St

19. 5/6 19 46 G.M. Schroeder
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 19 46 at 7:30 a.m

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 44 to May 5 19 46
 and that I last saw him alive on May 4 19 46

Immediate cause of death Generalized metastasis DURATION 1 yrs

Due to Infectious Carcinoma of
 Due to Left Breast 2 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Solomon Sherman M.D.

M. D. or other

Address 2424 Eutan Pl Date signed 5/5/46

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UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

RECORDED

MAY 8 1946

BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-8

CERTIFICATE OF DEATH

04601

32

Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
 City or town Mount Wilson
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 yr. 1 mo. 12 days
 Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
 How long in hospital or institution 1 yr. 1 mo. 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County
 City or town Baltimore, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 907 E. Chase Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Rosalie Iczkowski

3. (b) Social Security Number

Unknown

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Divorced
 6.(b) Name of husband or wife Stanley Iczkowski
 6.(c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) February 8, 1922
 8. AGE: Years 24 Months 2 Days 24 If less than one day hrs. min.

9. Birthplace Eastport, Maryland
 (Town, county, and state)
 10. Usual occupation None
 11. Industry or business

12. Name Alexander Johnson
 13. Birthplace Philadelphia, Pennsylvania
 14. Maiden name Rosalie Lindeman
 15. Birthplace Baltimore, Maryland

16. Informant Mrs. Rosalie Iczkowski
 Address 907 E. Chase St., Balto., Md.

17. Burial Date thereof May 4, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Cedar Bluff Cemetery
 Location Annapolis, Maryland

18. Funeral director E. Willis LaMoreau
 Address 4510 Liberty Hgts. Ave., Balto., Md.

19. May 2, 19 46 Earl T. Webster
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2, 19 46, at 11:15 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20, 19 45, to May 2, 19 46, and that I last saw him/her alive on May 2, 19 46.

Immediate cause of death Pulmonary Tuberculosis
 DURATION 4 yrs. 6 mos.

Due to Tubercle Bacilli

Due to

Other conditions None

(Include pregnancy within 8 months of death)

Major findings of operations No operation
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Stewart S. Shaffer M.D. or other

Address Mount Wilson, Md. Date signed 5/2/46

Rec'd 5-3-46 Dr. E. E. Nichols

RECEIVED
MAY 5 1946
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B-1

CERTIFICATE OF DEATH

04602 32
Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
City or town Mount Wilson, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs., 7 mos., 21 days
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 2 yrs., 7 mos., 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County _____
City or town Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 615 S. Montford Avenue
(If rural, give LOCATION)
2. (a) If veteran, name war _____

3. (a) FULL NAME

Thomas Jesionowski

3. (b) Social Security Number

Unknown

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
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6. (b) Name of husband or wife Bertha Jesionowski

7. Birth date of deceased (mo., day, yr.) December 29, 1895
6. (c) If alive, give age _____ years

8. AGE:	Years	Months	Days	If less than one day
	<u>50</u>	<u>4</u>	<u>19</u>	_____ hrs. _____ min.

9. Birthplace Poland
(Town, county, and state)

10. Usual occupation Tailor

11. Industry or business _____

FATHER
12. Name Wojcieck Jesionowski
13. Birthplace Poland

MOTHER
14. Maiden name Francis Wolaniec
15. Birthplace Poland

16. Informant Thomas Jesionowski
Address 615 S. Montford Ave., Balto., Md.

17. Burial Burial Date thereof May 21, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Holy Rosary Cemetery
Location German Hill Rd., Baltimore, Md.
Fialkowski Funeral Home

18. Funeral director _____
Address 2007 Eastern Ave., Balto., Md.

19. May 18, 1946 Earl F. Webster
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18, 1946 2:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 27, 1943 to May 18, 1946
and that I last saw him alive on May 18, 1946

Immediate cause of death Pulmonary Tuberculosis DURATION 7 Yrs.

Due to Tubercle Bacilli

Due to _____

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations No operation

_____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Stewart S. Shaffer M.D. M.D. or other _____

Address Mount Wilson, Md. Date signed 5/18/46

Rec'd 5-22-46 Dr. E. E. Nichols

MARGIN RESERVED FOR BINDING

VS A15 945-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 23 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 yrs., 10 mos., 26 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 6 yrs., 10 mos., 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Calvert
 City or town..... Brome's Island
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

William Jett

3. (b) Social Security Number

4. Sex..... male 5. Color or race..... white 6. (a) Single, married, widowed, or divorced..... single
 6. (b) Name of husband or wife.....
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... April 12, 1892
 8. AGE: Years..... 54 Months..... 1 Days..... 4 If less than one day..... hrs. min.

9. Birthplace..... Calvert County, Maryland
 (Town, county, and state)
 10. Usual occupation..... Farmer
 11. Industry or business..... Farm
 12. Name..... Louis Jett
 13. Birthplace..... Readsville, Virginia
 14. Maiden name..... Margaret Watson
 15. Birthplace..... Prince George's Co., Md.

16. Informant..... Hospital records
 Address..... Catonsville-28, Maryland
 17. Burial Date thereof..... 5-19-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Brome's Island Cem.
 Location.....

18. Funeral director..... Robert Blackness
 Address..... Prince Georges Co. Md.
 19. 5-18- 19 46 Harvey J. Miller
 (To be filled by registrar) Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 16 19 46 at 5:00 a.m.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
June 20 19 39 to May 16 19 46
 and that I last saw him alive on May 16 19 46

Immediate cause of death..... Broncho pneumonia DURATION..... 4 days
 Due to.....
 Due to.....
 Other conditions..... General paresis Indefinite
 (Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.....
 Autopsy results..... none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?.....
Isadore Tuerk
 23. SIGNATURE..... Isadore Tuerk, M.D. M. D. or other
 Address..... Catonsville-28, Md. Date signed 5-16-46

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 20 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0460437

Reg. Dist. No. 37

1. PLACE OF DEATH:

County

City or town

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Ward No.

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

18. Informant

Address

17.

(Burial, cremation, or removal, which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9
81419

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1842)

CERTIFICATE OF DEATH

04605

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

16. Duxing Ave.
How long in hospital or institution? 3 1/2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Baltimore

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3214 Elgin Ave.
(If rural, give LOCATION)

2. (a) If veteran, name war ✓

3. (a) FULL NAME

Mabel Belle Koch

3. (b) Social Security Number

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

8. (b) Name of husband or wife Daniel Jacob Koch

7. Birth date of deceased (mo., day, yr.) August 11, 1878

8. (c) If alive, give age 67 years

8. AGE: Years 67 Months 8 Days 26 If less than one day
hrs. min.

9. Birthplace Illinois
(Town, county, and estate)

10. Usual occupation at home

11. Industry or business Stephens Meyer

12. Name Penna

13. Birthplace Penna

14. Maiden name Hannah McKinney

15. Birthplace Penna

16. Informant Harry H. Koch

Address 300 College Ave State College Pa.

17. Burial May 10, 1946

(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Millheim

Location Millheim Pa.

18. Funeral director Harry H. Amador

Address 4204 Ridgewood Ave

19. 5/8/46 Registrar Quadrin

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 19 46 at 4:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 29 19 45 to May 7 19 46

and that I last saw h. ex alive on May 7 19 46

Immediate cause of death Pulmonary edema

Due to Intermittent Hypertensive

cardiovascular renal disease

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John J. Bowen

Address 20 E. Preston St. Balt. Md.

Date signed

M. D. or other

MARGIN RESERVED FOR BINDING

49 A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

Reg. Dist. No. 04606 44

1. PLACE OF DEATH:

County SPRINGFIELD City or town SPRINGFIELD
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 917 N. Hollington Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Joseph Kotzum
4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Married

3. (b) Social Security Number

8.(b) Name of husband or wife Rose Kotzum

6.(c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) May 12, 1895

8. AGE: Years 51 Months 1 Days 1 It less than one day hrs. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual occupation Machinist Helper

11. Industry or business Ship Building

12. Name Joseph Kotzum

13. Birthplace Austria

14. Maiden name Not known

15. Birthplace Austria

18. Informant Rose Kotzum

Address 917 N. Hollington Ave

17. Burial Date thereof 5-16-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Mary's Home

Location Baltimore Md.

18. Funeral director Vivian Brockman

Address 900 N. Chester St 5

19. 51.4 45 Ann
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-13-46 19..... at 11:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19..... to 19..... and that I last saw him alive on 19.....

Immediate cause of death Coronary Occlusion

DURATION

10 min.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. B. Davis M.D.

Address W. D. or other

Date signed 5-16-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04607

Reg. Dist. No. *H*

1. PLACE OF DEATH:

County *Baltimore*City or town *Lundall*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *MD* County *Balt*City or town *Lundall*
(If outside city or town limits, write RURAL and give nearest town)Street No. *80 Portolap*
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Lorrene Edith Lang

3.(b) Social Security Number

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

—

6.(b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Jan 18

6.(c) If alive, give age years

1946

8. AGE:

Years

Months

Days

If less than one day

4

hrs.

min.

9. Birthplace

Balto
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

Herman Lang

13. Birthplace

Baltimore

MOTHER

14. Maiden name

Edith Bodice

15. Birthplace

Pennsylvania

16. Informant

Address

*Herman Lang**80 Portolap Rd*

17.

(Burial, cremation, or removal, Which?)

Cemetery or crematory

Location

Date thereof *May 21*
(month)/(day) (year)*Oak Lawn Cem**City*

18. Funeral director

Address

*Wenick Funeral Home**200 S. Calhoun St*

19.

(Date rec'd by registrar)

Registrar

5/21/46 H. M. Lang

MEDICAL CERTIFICATION

20. DATE OF DEATH *May 18* 19 *46* at *12:45* P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 19 *46* to *May 18* 19 *46*and that I last saw him alive on *May 18* 19 *46*

Immediate cause of death

Thrombosis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured in motor

Injured at work?

23. SIGNATURE

M. B. Davis, M.D.
Wyn. med. exam. - Baltimore
5-20-46

Address

Date signed *5-20-46*

RECEIVED

MAY 30 1946

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH:

County Baltimore
City or town Raspeburg Baltimore 6 Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

6813 Golden Ring Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. As in No 1
(If rural, give LOCATION)

2.(a) If veteran, name war No

3. (a) FULL NAME

Caroline V Lantz

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Charles W Lantz 6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1862

8. AGE: Years 83 Months 11 Days 20 If less than one day

9. Birthplace Balto Co Md. (Town, county, and state)

10. Usual occupation At Home

11. Industry or business

12. Name Henry J. Volz

13. Birthplace Germany

14. Maiden name Unknown

15. Birthplace

16. Informant Mrs Henry E Zang

Address 6813 Golden Ring Road

17. Burial Date thereof 5/13/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Zion Lutheran

Location Stemmers Run

18. Funeral director Lasswell Funeral Home

Address 7401 Belair Road

19. May 11- 19 46 Ans G. L. Ruppman
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9, 19 46, at 11-40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1946 to May 9, 19 46

and that I last saw him alive on May 9, 19 46

Immediate cause of death Senile heart

DURATION

Due to age

Due to

Other conditions Asternal Lubron

(Include pregnancy within 3 months of death)

Major findings of operations

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ans G. L. Ruppman M. D. or other

Address 2105 N Charles St Date signed May 10/46

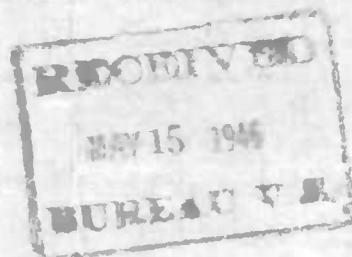
MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B72)

CERTIFICATE OF DEATH

 ★C4609 43
 Reg. Dist. No.

1. PLACE OF DEATH:

County... BaltimoreCity or town... Raspeburg
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? life

Hospital, institution, or street address where death occurred:

7401 Belair Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Balto.City or town... Raspeburg
(If outside city or town limits, write RURAL and give nearest town)Street No. 7401 Belair Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

HENRY C. LASSAHN

3. (b) Social Security Number

NONE

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married8.(b) Name of husband or wife... Marie C. Lassahn

8.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.) September 9, 1881

8. AGE:

Years

Months

Days

If less than one day

64812

hrs.

min.

9. Birthplace... Balto. Co., Md.

(Town, county, and state)

10. Usual occupation... Funeral Director & Embalmer

f1. Industry or business

12. Name... Frederick W. Lassahn13. Birthplace... Baltimore, Md.14. Maiden name... Eliza M. Duemer15. Birthplace... Germany16. Informant... Mrs. Henry C. LassahnAddress 7401 Belair Rd., Balto. 6, Md.17. burial

(Burial, cremation, or removal. Which?)

Date thereof May 25, 1946
(month) (day) (year)Cemetery or crematory... Loudon ParkLocation... Baltimore, Md.18. Funeral director... Geo. L. Beyer JrAddress 1512 Hollins St.19. May 22 1946

(Date read by registrar)

Ime. J. L. Reifmiller

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... May 21 1946 at 8:12 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 10 1946 to May 21 1946and that I last saw him alive on May 21 1946

Immediate cause of death...

Cerebral embolism

DURATION

40 hoursDue to... Valvular heart disease -mitral stenosis & insufficiency15 years

Due to...

Other conditions... Chronic interstitialne phritis10 years(?)

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE...

Adam Glwiss

M. D. or other

Address 6232 Belair Road Date signed May 21, 1946

RECEIVED
MAY 25 1946
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

County BALTIMORECity or town TOWSON
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Since April 19, 1946

Hospital, institution, or street address where death occurred:

SHEPPARD AND ENOCH PRATT HOSPITALHow long in hospital or institution? Since April 19, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County -City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 2822 Cold Spring Lane

(If rural, give LOCATION)

2(a) If veteran, name war -

3. (a) FULL NAME

MIRIAM LAZARUS

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

-6. (c) If alive, give age - years

7. Birth date of

deceased (mo., day, yr.)

Nov. 15, 1928

8. AGE:

Years

Months

Days

It less than one day

17524hrs.min.

9. Birthplace

Baltimore City, Maryland

(Town, county, and state)

10. Usual occupation

Student

11. Industry or business

FATHER

12. Name

Isaac Lazarus

MOTHER

13. Birthplace

Knoxville, Tenn.

14. Maiden name

Sophia Berman

15. Birthplace

Baltimore City, Md.

16. Informant

HOSPITAL RECORDS

Address

Towson 4, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

5-12-46

(month) (day) (year)

Cemetery or crematory

Baeti Kereur

Location

18. Funeral director

Jac Lewis Inc.

Address

1439 E. Baeti St

19.

(Date rec'd by registrar)

5-9-46W. W. Elgin

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9, 1946 at 2:18 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 19, 1946 to May 9, 1946and that I last saw him alive on May 9, 1946

Immediate cause of death

Chronic endocarditis

DURATION

4 yr.

Due to

Acute rheumatic fever4 yr.

Due to

Other conditions

Depressive psychosis6 weeks

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. W. ElginW. W. Elgin, M. D.

M. D. or other

Address TOWSON, MD.Date signed May 9 1946

RECEIVED

CERTIFICATE OF DEATH

RECEIVED

MAY 10 1946

BUREAU V.E.

Evidence for addition of name
of town where death occurred is
shown on
FILM No. 104 MAY 15 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

CERTIFICATE OF DEATH

04611

Reg. Dist. No. 180

1. PLACE OF DEATH:
County Harford Co. Baltimore county
City or town Bradshaw (postal guide;
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1-5-17-46
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
Robert H. Lingham

3. (b) Social Security Number

4. Sex male 5. Color or race col 6. (a) Single, married, widowed, or divorced married
8. (b) Name of husband or wife Jennie Lingham 6. (c) If alive, give age 65 years
7. Birth date of deceased (mo., day, yr.) Aug 1874
8. AGE: 71 Years Months Days If less than one day
..... hrs. min.

9. Birthplace Harford Co Md (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business

MOTHER FATHER
12. Name Henry Lingham
13. Birthplace Harford
14. Maiden name Helen Norton
15. Birthplace Harford Co Md
10. Informant Jennie Lingham
Address Bradshaw
17. Burial Date thereof 5-9-46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory John Wesley
Location Harford Co Md
18. Funeral director Mr. Francis A. Kemley
Address 578 W. Biddle St
19. May 7 19 46 Marie M. Moulton
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH May 5, 1946, at 6:30 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 8, 1946, to May 5, 1946
and that I last saw him alive on May 4, 1946
Immediate cause of death Cerebral Hemorrhage DURATION 2 days
Hypertensive Cardio-
Vascular Disease 5 yrs
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
Clifford F. Hudson M.D.
23. SIGNATURE Lark, Md. M. D. or other
Address Date signed 5/7/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 9 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04612

Reg. Dist. No. 41

1. PLACE OF DEATH:

County BaltimoreCity or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)Street No. 12 Kinship
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Athalia A. Lloyd

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife William I. Lloyd

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 22, 1873

8. AGE: Years Months Days If less than one day

72 8 22 hrs. min.

9. Birthplace Wilmington, Del.
(Town, county, and state)10. Usual occupation At home

11. Industry or business

12. Name Georg Alden13. Birthplace Delaware

14. Maiden name

15. Birthplace

16. Informant Mrs. Mary GeigerAddress 3011 Dundalk Ave.17. Burial Date thereof May 17, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bethel CemeteryLocation Chesapeake City, Md.18. Funeral director Ullrich Funeral HomeAddress 2008 Orleans St.,19. 5-16-46 Accident

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 14th 19 46 at 9:40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 14th 19 46 to May 14th 19 46and that I last saw him alive on May 14th 19 46

Immediate cause of death

A-C-V. DiseaseDue to Acute Cardiac DistentionC. Pulmonary Edema

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature MB Davis MDAddress Dundalk - 2211 M. D. or otherDate signed 5/14/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 182

CERTIFICATE OF DEATH

04613

Reg. Dist. No. 44

1. PLACE OF DEATH:

County BaltimoreCity or town Middle River
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1 C Maple Drive, Oak Grove Apts.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BALTOCity or town Middle River
(If outside city or town limits, write RURAL and give nearest town)Street No. 1 C - MAPLE DR. OAK GROVE
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

ANN MARIE LONG.

3. (b) Social Security Number

4. Sex F

5. Colour or race

W.

6. (a) Single, married, widowed, or divorced

Single6. (b) Name of husband or wife --8. (c) If alive, give age -- years7. Birth date of deceased (mo., day, yr.) Dec. 30, 1945

8. AGE: Years Months Days If less than one day

--413-- hrs.-- min.9. Birthplace Balto., Md.
(Town, county, and state)10. Usual occupation --11. Industry or business --12. Name Earl George Long13. Birthplace North Collins, N. Y.14. Maiden name Caroline Marie Braun15. Birthplace Buffalo, N. Y.16. Informant Mr. Earl George LongAddress North Collins, N. Y.17. Removal Date thereof 5/14/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Pinecrest Cem.Location Buffalo, N. Y.18. Funeral director WM. J. TICKNER & SONSAddress Balto., Md.19. 5-13 44 aw Redick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1946, at 6:45 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19-- to 19--and that I last saw him alive on 19--Immediate cause of death Suffocation

DURATION

Due to --Due to --Other conditions --

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. --Autopsy results --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5-13-46Where did injury occur? Middle River (City or town) BALTO (County) MD (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury Head caught under pulley Injured at work? --23. SIGNATURE M. B. W. [Signature] M. D. or other --Address Middle River, Md. Date signed 5/13/46

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Baltimore
 (b) City or town Reisterstown
 (If outside city or town limits, write RURAL and give town)
 (c) Street address, hospital, or institution: Int. Pleasant Sanatorium
 (d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
 (e) Length of stay in this community (yrs., mos., or days) _____

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Maryland (b) County _____
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 4015 Fairfax Road
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? 33 years

3 (a) FULL NAME

Harry Londer

3 (b) If veteran, name war

3 (c) Social Security

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Bessie Henrietta Londer

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

March 9, 1897

8. AGE:

Years 49

Months 2

Days 9

If less than one day

____ hr. ____ min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual occupation

Grocer

11. Industry or business

MOTHER FATHER

12. Name

Michael Londer

13. Birthplace

Russia

14. Maiden Name

Ella ?

15. Birthplace

Russia

16 (a) Informant

Bessie Londer (wife)

(b) Address

4015 Fairfax Road

17 (a)

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location

(b) Date thereof

5-20-46

(month) (day) (year)

18 (a) Funeral director

(b) Address

1439 E. Baltimore St.

19 (a)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. Date of death May 18, 1946 at 12 05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 14, 1946 to May 18, 1946, and that I last saw him alive on May 18, 1946

Immediate cause of death

Myocardial Collapse

Duration

Due to

Congestive Heart Failure

2 weeks

Due to

Pneumonia

10 weeks

Due to

Subcutaneous

15 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy

Subcutaneous Pyothorax on Right. Others same as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide _____

(b) Date of occurrence _____

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____

(Specify type of place)

(e) Means of injury _____

23. Signature

Albert J. Shrier

M. D. or other

Address

Reisterstown, Md

Date signed

May 18, 1946

MARGIN RESERVED FOR BINDING

VS. A15A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (469)

CERTIFICATE OF DEATH

04615 30
Reg. Dist. No.

I. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 13 yrs., 6 mos., 12 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 13 yrs., 6 mos., 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town 1218 Marshall Street
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Baltimore
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Nicholas Lowry (Stephen Lowry or Larry)

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 8. (b) Name of husband or wife Bertha Fenger
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) January 9, 1898
 8. AGE: Years 48 Months 3 Days 28 If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
 (Town, county, and state)
 10. Usual occupation Laborer
 11. Industry or business Post Office
 12. Name ?
 13. Birthplace Maryland
 14. Maiden name ?
 15. Birthplace Maryland

16. Informant Hospital records
 Address Catonsville-28, Maryland
 17. Burial Date thereof 5-11-1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Burial Cedar Hill
 Location A. G. C. Md.
 18. Funeral director Thyng & Flepping
 Address 1416 Right St.
 19. 5-10 19 46 aw Hedrick
 (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 19 46 at 1:55 pm
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
October 25 19 32 to May 7 19 46
 and that I last saw him alive on May 7 19 46

Immediate cause of death Carcinoma
head of the pancreas
with metastases
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

DURATION

Major findings of operations _____
 _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
Isadore Tuerk
 23. SIGNATURE Isadore Tuerk, M.D. M. D. or other
Catonsville-28, Md. Date signed 5-9-46
 Address _____

MARGIN RESERVED FOR BINDING

VS A15

9-55135N

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

04616

Reg. Dist. No.

44

1. PLACE OF DEATH:

County... Baltimore
 City or town... Fort Howard, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 day
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Fort Howard, Md.
 How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County...
 City or town... Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1714 W. Mosher Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war... ★

3. (a) FULL NAME

LOYD, George

3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Divorced

6.(b) Name of husband or wife Divorced

7. Birth date of deceased (mo., day, yr.) 4-9-82 8.(c) If alive, give age... years

8. AGE: Years 64 Months 1 Days 11 If less than one day... hrs. min.

9. Birthplace Jones County, Ga.
 (Town, county, and state)

10. Usual occupation Retired from U.S. Army

11. Industry or business

MOTHER FATHER
 12. Name...
 13. Birthplace...
 14. Maiden name...
 15. Birthplace...

16. Informant Clinical Records, Vets. Adm. Hosp.
 Address Fort Howard, Md.

17. Burial Date thereof 5-27-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Jones County, Ga.

18. Funeral director Charles R. Law
 Address 802 Madison St., Balto. Md.

19. May 25 19 46 a. w. H. Smith
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 19 46 at 12:45 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 19 46 to May 20 19 46
 and that I last saw him alive on May 20 19 46

Immediate cause of death...
BRONCHOPNEUMONIA, BILATERAL

DURATION

Unknown

Due to...

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op. ...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert M. Cullison
R. M. CULLISON, M. D. M. D. or other

Address Fort Howard, Md. Date signed May 21

1946

1804 Druid Hill ave

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04617

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 yrs., 6 mos., 19 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 12 yrs., 6 mos., 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George
 City or town Laurel
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name War _____

3. (a) FULL NAME

Noble Mallonee

3. (b) Social Security Number

4. Sex male
 5. Color or race white
 6.(a) Single, married, widowed, or divorced single
 6.(b) Name of husband or wife _____
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) February 9, 1886
 8. AGE: Years 60 Months 3 Days 12
 If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
 (Town, county, and state)
 10. Usual occupation Farmer
 11. Industry or business Farm
 12. Name Oliver W. Mallonee
 13. Birthplace Maryland
 14. Maiden name Lavinia Beavin
 15. Birthplace Maryland

16. Informant Hospital records
 Address Catonsville-28, Md.

17. Burial Date thereof May 26, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Joy Still Cemetery, Laurel
 Location W.P. Selby

18. Funeral director Isadore Tuerk
 Address 401 Washington Blvd Laurel, Md

19. 5-25 1946
 (by registrar) Registrar Harvey Miller
Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 19 46, at 9:00 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
November 2 1933 to May 21 19 46
 and that I last saw him alive on May 21 19 46

Immediate cause of death Carcinoma of the liver,
source undetermined
 DURATION Indefinite

Due to _____
 Due to _____
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE Isadore Tuerk, M.D.
 Address Catonsville-28, Md. M. D. or other 5-22-46

Date signed _____

TIME

DATE OF ENTRY IN THE OFFICE

NO. OF THE OFFICE

NAME OF THE OFFICE

NAME OF THE OFFICE

NAME OF THE OFFICE

NAME OF THE OFFICE

NAME OF THE OFFICE

NAME OF THE OFFICE

RECEIVED
MAY 25 1946
BUREAU V B.

Remained in

ARTISTAN LEDGER

PRO CONTENT

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH:

County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Arch Nursing Home

How long in hospital or institution?

3. (a) FULL NAME

Kate D. Marriott

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

8. (b) Name of husband or wife

T. Leigh

7. Birth date of deceased (mo., day, yr.)

Feb 6 1857

8. AGE:

Years 89Months 3Days 8

If less than one day

hrs. min.

9. Birthplace

Reading Pa
(Town, county, and state)

10. Usual occupation

housewife

11. Industry or business

Alex. Smith

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Mrs. Eugene Martine

Address

212 W. Down St.

17. (Burial, cremation, or removal, Which?)

Date thereof

3/17/46
(month) (day) (year)

Cemetery or crematory

London Park

Location

Baltimore Md

18. Funeral director

William L. G. Co.

Address

1217 St. Paul St.19. 5-16

(Date rec'd by registrar)

19. 46

(Date rec'd by registrar)

PA Hedrich

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 14 1946 at 1545 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

DEC 10 1945 to MAY 1946and that I last saw h.ER. alive on May 2 1946

Immediate cause of death

arteriosclerosisHypertensionDue to Cerebral Hemorrhage withleft hemisphereDue to Coronary Thrombosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Ralph G. Hills

M. D. or other

Address

15 E. Edge St.Date signed May 14 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04619

Reg. Dist. No. 44

1. PLACE OF DEATH:

County BaltoCity or town Evergreen Farm
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Back River neck Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County BaltoCity or town Back River neck Rd.
(If outside city or town limits, write RURAL and give nearest town)Street No. Evergreen Farm
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Joseph mattheu4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 18888. AGE: Years 58 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Baltimore Co. md.
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name John J. mattheu13. Birthplace Austria14. Maiden name Unknown

15. Birthplace

16. Informant James MattheuAddress Evergreen Farm17. Burial Date thereof 5/15/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Holy RedeemerLocation Belair Rd.18. Funeral director John J. ConnellyAddress 477 Eastern Ave. - Inc 3119. May 14 19 46 John J. Connelly
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 19 46 at 1:00 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19 45 to May 12, 19 46and that I last saw him alive on May 11, 19 46Immediate cause of death Chronic valvular heart diseaseDuration ?Due to Pulmonary oedema 24 hrsDue to Chronic alcoholism ?Other conditions Arterio-sclerosis ?

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Benedic BrunsAddress 3037 O'Donnell St MAY 14 1946

3037 O'Donnell St.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CORRECTED COPY

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 103 days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp. Ft. Howard, MarylandHow long in hospital or institution? 103 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AACity or town Gambrille
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)2.(a) If veteran, name war S.A.W. ✓

3.(a) FULL NAME

James A. Matz

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

MaleWhiteMarried6.(b) Name of husband or wife Carrie E. Matz6.(c) If alive, give age 61 years7. Birth date of deceased (mo., day, yr.) Nov. 27, 18788. AGE: Years 67 Months 5 Days 15 If less than one day
.....hrs.min.9. Birthplace Reading, Pa.
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business

12. Name Jim Matz13. Birthplace Pennsylvania14. Maiden name Annie Ziegler15. Birthplace Reading, Pa.16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland17. Burial Date thereof 5-12-1946
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory CemeteryLocation Reading, Pa.18. Funeral director Oder Funeral Home, Inc.Address 4644 York Rd., Baltimore, Md.19. 5-14-46 19. AW. Hedrichs
(Date rec'd by registrar) (Signature) Registrar

3.(b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1946 at 6:10 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan. 30, 1946 19. to May 13 19. 46
and that I last saw him alive on May 13 19. 46Immediate cause of death Heart Disease - 932
Hypertension and coronary myocardial Since
insufficiency, auricular fibrilla- Dec. 26, 44
tion. 952Due to 932Other conditions Nephrosclerosis 1312

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Robert M. Cullison
R. M. CULLISON, M.D. CLIN. DIR. M.D. or other
Address Ft. Howard, Md. Date signed 5-13-46

RECEIVED

MAY 20 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (136-0)

04621

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 17 days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp. Ft. Howard, Maryland
 How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 243 N. Schroder St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war VV-I

3. (a) FULL NAME

LEVI MAXWELL

3. (b) Social Security Number

4. Sex Male 5. Color or race Col. 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Loretta Maxwell
 6.(c) If alive, give age 53 years
 7. Birth date of deceased (mo., day, yr.) December 25, 1888
 8. AGE: Years 57 Months 4 Days 7 If less than one day hrs. min.

9. Birthplace Georgia
 (Town, county, and state)
 10. Usual occupation Fireman
 11. Industry or business
 12. Name Levi Maxwell
 13. Birthplace Georgia
 14. Maiden name Lucy Foster
 15. Birthplace Georgia

16. Informant Clinical Records, Vets. Adm. Hosp.
 Address Fort Howard, Maryland

17. Burial Date thereof May 6, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory National Cemetery
 Location Mrs. Katie R. Williams

18. Funeral director 322 N. Schroder St.
 Address 5/4/46

19. (Date rec'd by registrar) 5/4/46 Registrar [Signature]

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 19 46 at 6:55 A. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15, 19 46, to May 2 19 46
 and that I last saw him alive on May 2 19 46

Immediate cause of death Uremia, chronic, severe DURATION 6 mos. plus

Due to Stricture of posterior urethra severe 6 yrs.

Due to Bilateral Hydronephrosis 2 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

..... Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Robert M. Cullison

23. SIGNATURE ROBERT M. CULLISON, CLINICAL DIRECTOR
 M. D. or other

Address Fort Howard, Maryland Date signed 5-2-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of **MARYLAND STATE**
& birth date of deceased is shown on **CITY HEALTH DEPARTMENT**
FILM No. **I 04 MAY 15 1946** **CERTIFICATE OF DEATH** (31-a)

Registered No. **38****1. PLACE OF DEATH:**

(a) Baltimore City, Maryland **Parkville**
(b) Street address **3010 Lavender ave**
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **md.** (b) County **04622**
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **1767 Gorsuch ave**
(If rural give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country.

3 (a) FULL NAME**Elizabeth Meyers**

3 (b) If veteran, name war

no

3 (c) Social Security Account

No. **no**

4. Sex

Female

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife

John H. Meyers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 21, 1858

8. AGE: Years

87

Months

8

Days

1

If less than one day

15

hr.

min.

9. Birthplace

Germany

(Town, county, and state)

10. Usual Occupation

Housework

11. Industry or business

FATHER

12. Name

Peter Gohs

13. Birthplace

Germany**MOTHER**

14. Maiden Name

Unknown

15. Birthplace

Unknown

16 (a) Informant

Mrs. John H. Meyers Jr

(b) Address

3010 Lavender ave17 (a) **Burial**

(Burial, cremation, or removal)

(b) Date thereof

5-8-46

(c) Cemetery or crematory

Rockwood Cem.

Location

Baltimore Md.

18 (a) Funeral director

Leonard J. Smith

(b) Address

5305 Harford Rd. Md.19 (a) **577**

(Date rec'd by registrar)

(b) **46****A.W. Petrus**

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 6 19 46 at **M**

21. I certify that death occurred on the date above stated; that I attended deceased from **April 24 19 46** to **May 6 19 46**, and that I last saw her alive on **May 5 19 46**.

Immediate cause of death

Bronchitis PneumoniaDue to **Heart disease**Due to **Myocardial degeneration**Due to **Chronic interstitial nephritis**

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at **M**

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature **S.F.A. Stevens**Address **2878 Harford Ave** Date signed **5-7-46**

Duration

3 d.**5 d.****14 d.****14 d.****PHYSICIAN**

Underline the cause to which death should be charged statistically.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 1244

CERTIFICATE OF DEATH

04623

1. PLACE OF DEATH:

(a) County Baltimore
 (b) City or town Sundalk
 (If outside city or town limits, write RURAL and give town)
 (c) Street address, hospital, or institution 1815 East Ave.
 (d) Length of stay in hospital or inst. (yrs., mos., or days) _____
 (e) Length of stay in this community (yrs., mos., or days) _____

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Ind. (b) County Balto
 (c) City or town _____
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 1815 East Ave. Sundalk
 (If rural give location)
 (e) If foreign born, how long in U. S. A.? _____ years

3 (a) FULL NAME

Anna May Miller

3 (b) If veteran, name war

3 (c) Social Security

No. _____

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

July 19

8. AGE:

Years

Months

Days

If less than one day

9

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual occupation

School girl

11. Industry or business

MOTHER FATHER

12. Name

John H. Miller

13. Birthplace

Baltimore

14. Maiden Name

Sophie Orlewski

15. Birthplace

Baltimore

16 (a) Informant

John H. Miller

(b) Address

1815 East Ave. Sundalk

17 (a)

Burial

(b) Date thereof

June 3/46

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St. Mary's

Location

Baltimore

18 (a) Funeral director

Fred W. Ozment

(b) Address

1930 Eastern Ave.

19 (a)

June 11/46

(b)

A. W. Hedrick

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. Date of death May 31 1946, at 3:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 31 1945, to May 31 1946, and that I last saw him alive on May 31 1946.

Immediate cause of death Toxemia

Duration

1 yr.

Due to Sarcoma right hip

with general metastases

2 yrs

Due to _____

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature

Geo. M. Baumgardner

M.D. or other

Address Balto 6 Ind

Date signed 5-31-46

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

CERTIFICATE OF DEATH

Reg. Date No. 44

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 Days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Maryland
 How long in hospital or institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wick
 City or town Waverly - Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name, war WW-I ✓

3. (a) FULL NAME

CLARENCE E. MOSER

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife Single
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) August 1, 1892
 8. AGE: Years 53 Months 9 Days 26 If less than one day _____ hrs. _____ min.

9. Birthplace Myersville, Maryland
 (Town, county, and state)
 10. Usual occupation _____
 11. Industry or business Unknown
 12. Name _____
 13. Birthplace _____
 14. Maiden name _____
 15. Birthplace _____

18. Informant Clinical Records, Vets. Adm. Hosp.
 Address Ft. Howard, Md.

17. Burial Date thereof 30-May-46
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Hagerstown Maryland
 Location _____

18. Funeral director Order Samuel Home One
 Address 4644 York Rd.

19. 5/28 46 R.W. Hedrick
 (Date rec'd by registrar) (year) (month) (day) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27, 1946, at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 24, 1946 to May 27, 1946
 and that I last saw him alive on May 27, 1946

Immediate cause of death Coronary Arteriosclerotic Heart Disease
 DURATION Unknown

Due to _____
 Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. J. Ryan
F. J. Ryan, Lt. Col., M.C. AGM. D. or other
 Address V.A. Ft. Howard, Md. Date signed 5-27-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-7

CERTIFICATE OF DEATH

04625

Reg. Dist. No. 33

1. PLACE OF DEATH:

County BALTIMORE

City or town REISTERSTOWN
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 wks

Hospital, institution, or street address where death occurred:

Now long in hospital or institution?

3. (a) FULL NAME

Christina C. Newbig

3. (b) Social Security Number

4. Sex FEMALE

5. Color or race White

6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife John J. Newbig

MARCH 1887 5. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 59 Months 2 Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation NONE

11. Industry or business NONE

12. Name Anton Volkert

13. Birthplace GERMANY

14. Maiden name ?

15. Birthplace ?

16. Informant GEORGE A. BECK

Address 1575 W. Pratt St

17. BURIAL Date thereof MAY 27 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory WESTERN

Location BALTIMORE MD

18. Funeral Pratt & Co. B. M. Walters

Address Pratt & Co. B. M. Walters

19. MAY 25 1946 9. W. Hodnick
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County BALTIMORE

City or town REISTERSTOWN
(If outside city or town limits, write RURAL and give nearest town)

Street No. CHROME MINE ROAD
(If rural, give LOCATION)

2. (a) If veteran, name war _____

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 24 1946 5:10 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-8-46 19. to 5-24-46 19.

and that I last saw him alive on 5-24-46 19.

Immediate cause of death Cerebral Decomposition

Due to hypertensive C-V. Disease

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE D. D. Caples M.D. M. D. or other _____

Address Baltimore Md. Date signed 5-24-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County BaltimoreCity or town Prestertown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 80 years

Hospital, institution, or street address where death occurred:

Cokeup Mill Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Prestertown
(If outside city or town limits, write RURAL and give nearest town)Street No. Cokeup Mill Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Jefferson Davis Norris

3. (b) Social Security Number

none

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

widowed

6.(b) Name of husband or wife

Martha Cabell Perkins6.(c) If alive, give age deceased years

7. Birth date of

deceased (mo., day, yr.)

Sept 2, 1865

8. AGE:

Years

80

Months

8

Days

28

If less than one day

hrs. min.

9. Birthplace

Prestertown, Baltimore Co., Md.
(Town, county, and state)

10. Usual occupation

lawyer (retired)

11. Industry or business

MOTHER

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. 5-31-1946

(Date rec'd by registrar)

1946

Mary B. E. Line

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1946, at 6:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1935 to May 30 1946and that I last saw him alive on May 29 1946

Immediate cause of death

MyocarditisDue to Arterio Sclerosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (whore?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed

5/31/46

M. D. or other

1403 Park Ave

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. PLACE OF BIRTH

3. SEX

4. AGE

5. DATE OF DEATH

6. TIME OF DEATH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. SIGNATURE OF DECEASED

10. SIGNATURE OF WITNESSES

11. NAME OF PHYSICIAN

RECEIVED
JUN 1 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04627

Reg. Dist. No. 32

1. PLACE OF DEATH:

County Baltimore
 City or town Mount Wilson
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 0 yrs., 1 mo., 11 days
 Hospital, institution, or street address where death occurred: Mt. Wilson
Branch, Md. Tuberculosis Sanatorium
 How long in hospital or institution? 0 yrs., 1 mo., 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Fullerton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4214 Cardwell Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

James Thomas Nunnelley

3. (b) Social Security Number

220-01-3761

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

January 18, 1920

8. AGE:

Years

Months

Days

If less than one day

26

3

17

hrs.

min.

9. Birthplace

Baltimore, Maryland

(Town, county, and state)

10. Usual occupation

Salesman

11. Industry or business

FATHER

12. Name

James T. Nunnelley

13. Birthplace

Irvin, Kentucky

MOTHER

14. Maiden name

Ella Barger

15. Birthplace

Texas, Maryland

16. Informant

James Thomas Nunnelley

Address

4214 Cardwell Ave., Fullerton, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof May 8, 1946

(month) (day) (year)

Cemetery or crematory

Parkwood Cemetery

Location

3310 Taylor Ave., Balto., Md.

18. Funeral director

Lassahn Funeral Home

Address

7401 Belair Road, Balto., Md.

19. May 5, 1946

(Date rec'd by registrar)

Earl T. Webster

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5, 1946, at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 24, 1946, to May 5, 1946

and that I last saw him alive on May 5, 1946

Immediate cause of death

Pulmonary Tuberculosis

DURATION

1 Yr.

Due to

Tubercle Bacilli

Due to

Other conditions

Tuberculous Laryngitis 3 Mos.

(Include pregnancy within 8 months of death)

Major findings of operations

No operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Stewart S Shaffer M.D.

D. or other

Address Mount Wilson, Md. Date signed 5/5/46

Rec'd 5-8-46 Dr. E. E. Nichols

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 9 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 792

CERTIFICATE OF DEATH

04628

Reg. Dist. No. 46

1. PLACE OF DEATH:

County BaltimoreCity or town Sparrows Pt.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William Paul

4. Sex

M

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Geraldine

7. Birth date of

deceased (mo., day, yr.)

Sept 17, 1898

6. (c) If alive, give age..... years

8. AGE:

Years 47Months 7Days 16

If less than one day

..... hrs. min.

9. Birthplace

Pa
(Town, county, and state)

10. Usual occupation

11. Industry or business

Bethlehem Steel

FATHER

12. Name

Frank Paul

13. Birthplace

Germany

MOTHER

14. Maiden name

unknown

15. Birthplace

Geraldine Paul

18. Informant

Burial

Cemetery or crematory

Baltimore

Location

Paul, 11 St

16. Funeral director

844 36 St

Address

5/4/46 Unpublished

19. (Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new born infants give residence of mother)

State

City or town

Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.

3426 Elm Ave
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 3 1946, at 2:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to 19.....

and that I last saw him..... alive on 19.....

Immediate cause of death

Coronary Occlusion

DURATION

40 min.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

..... Date of (State)

Where did injury occur?

..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. B. Davis M.D.
Sup. med. exam - BaltimoreAddress Dundalk, Md. Date signed 5/3/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04629

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:

County Baltimore
 City or town Relay
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 18 yrs
 Hospital, institution, or street address where death occurred:
5009 Tulip ave
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md County Baltimore
 City or town Relay
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5009 Tulip ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war none

3. (a) FULL NAME

Joseph Anthony Resagno

3. (b) Social Security Number

none

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed
 8. (b) Name of husband or wife Emelia Ratalata
 7. Birth date of deceased (mo., day, yr.) Sept 22 - 1861 8. (c) If alive, give age _____ years
 8. AGE: Years 84 Months 7 Days 27 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore ct
 (Town, county, and state)
 10. Usual occupation Merchant
 11. Industry or business Private Business
 12. Name John Pressagno
 13. Birthplace Genoa Italy
 14. Maiden name Mary Pressagno
 15. Birthplace Genoa Italy

16. Informant Miss Catherine Resagno
 Address 5008 Tulip ave, Relay Md
 17. Burial Date thereof May 21/46
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Mt. Olivet
 Location Washington D.C.
 18. Funeral director Larry H. Hutzler
 Address 4101 Edmondson ave.

19. May 20 1946 George Kieffer
 (by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1946, at 8 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/12/46 1946, to 5/18/46 1946,
 and that I last saw him alive on 5/18/46 1946.
 Immediate cause of death Myocarditis
with compensation
 Due to General arteriosclerosis
 Due to arteriosclerosis
 Other conditions senility

DURATION

11 years
17 years

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE B. H. Brumbaugh M. D. or other _____
 Address 3609 Ave. Delmar Date signed 5/18/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-13M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REC-117
JUN 2 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

04630

Reg. Dist. No. 30

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 year, 5 mos., 11 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 1 year, 5 mos., 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Harford
 City or town..... ?
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Edward Peterson

3. (b) Social Security Number

4. Sex..... male 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... single
 6.(b) Name of husband or wife.....
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... September 1861
 8. AGE: Years..... 84 Months..... 8 Days..... ? If less than one day..... hrs. min.

9. Birthplace..... Harford County, Maryland
 (Town, county, and state)
 10. Usual occupation..... Painter, stone mason
 11. Industry or business..... Building
 12. Name..... Thomas Peterson
 13. Birthplace..... ?
 14. Maiden name..... Sally ?
 15. Birthplace..... ?

16. Informant..... Hospital records
 Address..... Catonsville-28, Maryland
 17. buried Date thereof..... June 6, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Spring Grove State Hospital
Catonsville 28, Maryland
 Location.....
Spring Grove State Hospital
 18. Funeral director.....
 Address..... Catonsville 28, Maryland
 19. June 6th 1946
 (Date rec'd by registrar) Harper D. Miller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 23 1946, at 12:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19....., to..... 19.....
 and that I last saw him..... alive on..... 19.....
 Immediate cause of death..... DURATION

Acute Cardiac Failure
 Due to.....
Cardio Vascular Disease
 Due to.....
Sudden death
Exposure
 Other conditions.....
 (Include pregnancy within 3 months of death)
 Major findings of operations..... Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE..... Dr. M. Kieffer M. D. or other
 Address..... 1010 Keede a road Date signed..... 5-23-46

RECEIVED
JUN 10 1945
BUREAU VS

04631

authorization received
Loudon Brooks Funeral director

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:

County Balto

City or town Cockeysville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Cockeysville Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. Cuba Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Jane Powell

3. (b) Social Security Number

4. Sex

F

5. Color or race

C.

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife Clarence Powell

7. Birth date of
deceased (mo., day, yr.)

unknown 1882

6.(c) If alive, give age 70 years

8. AGE:

Years

Months

Days

If less than one day

63

?

?

hrs. min.

9. Birthplace Balto. Co. Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Charles Johnson

13. Birthplace Balto Co. Md.

14. Maiden name Sarah Jones

15. Birthplace Balto. Co. Md.

16. Informant Thomas Beard

Address Monkton, Md.

17. Burial Date thereof May 19 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Stephenson Chapel

Location Sparks, Md.

18. Funeral director Loudon M. Brooks

Address Sparks, Md.

19. May 18 46 Wilmer C. Ensor

(Date rec'd by registrar)

19

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16, 1946 at 10:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. alive on 19.

Immediate cause of death

DURATION

Coronary Occlusion

Sudden

Due to and suddenly while

Due to driving car.

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE John L. Gregor, M.D.

M. D. or other

Address Lansan, Md. Date signed 5/16/46

(Coroner's report)

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 22 1946

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-21

CERTIFICATE OF DEATH

04632

Reg. Diat. No. 57

1. PLACE OF DEATH:

County Baltimore
City or town Lutherville
(if outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred:
Burton Avenue
How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Lutherville
(if outside city or town limits, write RURAL and give nearest town)
Street No. Burton Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war -----

3.(a) FULL NAME

NANCY HARRIETT POWERS

3.(b) Social Security Number

216-05-9978

4. Sex Female	5. Color or race White	6.(a) Single, married, widowed, or divorced Single
------------------	---------------------------	---

6.(b) Name of husband or wife -----

7. Birth date of deceased (mo., day, yr.) September 24, 1889
8.(c) If alive, give age ----- years

8. AGE:	Years	Months	Days	If less than one day
	57	8	1	hrs. min.

9. Birthplace Providence, Rhode Island
(Town, county, and state)

10. Usual occupation Comptometer Operator

11. Industry or business Gen. Acct. Office, U.S.Gov.

12. Name Henry Powers

13. Birthplace England

14. Maiden name Flora MacKay

15. Birthplace Novia Scotia

16. Informant Mrs. William H. Robinson

Address Burton Ave., Lutherville, Md.

17. Burial Burial Date thereof May 28, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Prospect Hill Cemetery

Location Towson, Maryland

18. Funeral director John Burns' Sons

Address Towson, Maryland

19. May 28 19 46 Wilmer C. Ensor
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH May 25, 19 46 at 2: M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 3-24 19 46 to 5-25 19 46
and that I last saw him alive on 5-25 19 46

Immediate cause of death	DURATION
<u>Congestive heart disease</u>	<u>5/14/46</u>
<u>Pulmonary embolus, left</u>	<u>4/11/46</u>
<u>Cerebral embolus</u>	<u>5/10/46</u>
<u>Phlebitis, both legs</u>	<u>2/20/46</u>

Other conditions -----

(Include pregnancy within 3 months of death)

Major findings of operations none

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ----- Date of -----

Where did injury occur? ----- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----

Means of injury ----- Injured at work? -----

23. SIGNATURE Bennett A. Steen

Address Lutherville, Md. M. D. or other 5/21/46

Date signed -----

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 6 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04633 92

1. PLACE OF DEATH:

County Balts.
 City or town Bedford Ave. - Pikesville, Ind.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 yrs.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Ind. County Balts.
 City or town Pikesville, Ind.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Bedford Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war * Spanish American

3. (a) FULL NAME

Harry Dewight Purdy

3. (b) Social Security Number

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Martha Belle Purdy

7. Birth date of deceased (mo., day, yr.) Sept 25 - 1878 8. (c) If alive, give age — years

8. AGE: Years 67 Months 7 Days 7 If less than one day — hrs. — min.

9. Birthplace Sumton Ohio
 (Town, county, and state)

10. Usual occupation Retired

11. Industry or business B + O. R. R.

12. Name Dewight Purdy

13. Birthplace Brownson Huron Co. Ohio

14. Maiden name Fannie F. Jinks

15. Birthplace Unknown

18. Informant Martha B. Purdy

Address Bedford Rd. Pikesville, Ind.

17. Burial Date thereof May 4 - 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory New Baltimore National

Location Fredricks Rd. & North Bend

18. Funeral director Frank H. Newell

Address Pikesville, Maryland

19. 5 - 4 - 19 46 Dr E E Nichols
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 19 46 at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 2 19 46 to May 2 19 46

and that I last saw him alive on May 2 19 46

Immediate cause of death Coronary Occlusion

DURATION

30 min.

Due to —

Due to —

Other conditions Hypertensive C. V. Disease 40 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations none Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of Injury — Injured at work? —

23. SIGNATURE A. D. Caples med. M. D. Exam.

Address Reisterstown, Ind. Date signed May 2 '46

RECEIVED
MAY 5 1946
BUREAU V.E.

N. B. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

P

1. PLACE OF DEATH

County

Baltimore

Village or City

Sparrow Point

No.

Registration Dist. No.

44

St.

Ward

Length of residence in city or town where death occurred

10 yrs.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME

Harry Quick

(HENRY JAMES QUICK)

(a) Residence: No.

813 E. 33rd St.

St.

Ward.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

married

5a. If married, widowed, or divorced

HUSBAND of (or) WIFE of

Allie Mae Watson Quick

6. DATE OF BIRTH (month, day, and year)

Jan. 1, 1884

7. AGE

Years

62

Months

4

Days

8

If LESS than

1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

Planning Dept

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

Beth. Steel. Sp. pt.

10. Date deceased last worked at this occupation (month and year)

5/9/46

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town)

Baltimore Maryland

FATHER

13. NAME

Henry James Quick, Sr

14. BIRTHPLACE (city or town)

Baltimore Md.

MOTHER

15. MAIDEN NAME

Fanning Ford

16. BIRTHPLACE (city or town)

Baltimore Md.

17. INFORMANT

Mrs Allie Mae Quick - widow

(Address)

813 E. 33rd St.

18. BURIAL, CREMATION, OR REMOVAL

Place

Baltimore Cem.

Date

5/13

19. 46

19. UNDERTAKER

Henry Sander & Sons, Inc

(Address)

North Ave & Broadway

20. FILED

5-9

19. 46

W. J. Quick

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

May 9

(Month)

(Day)

1946 (Year)

22.

I HEREBY CERTIFY, That I attended deceased from

May 9, 1946, to May 9, 1946

I last saw him alive on

19

; death is said

to have occurred on the date stated above, at 7:25 a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Coronary occlusion

Date of onset

Immediate

Other Contributory Causes of importance:

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide?

Date of injury

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

W. J. Quick

M. D.

(Address)

Regency Medical Center

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No.

Baltimore Md.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
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Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

04685

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Balto
City or town Middle River Balto 20
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mo.
Hospital, institution, or street address where death occurred:
Brick Dr. - Box 60 - Balto 20, Md. Middle River

How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County _____
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 647-N. 4th St. N.E.
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

FRANK T. RAZZY

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) March 4th 1854 6.(c) If alive, give age _____ years

8. AGE: Years 92 Months 2 Days 22 If less than one day _____ hrs. _____ min.

9. Birthplace New York
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name Elanzo Razy
13. Birthplace France

14. Maiden name Rebecca Tylon
15. Birthplace Unknown

16. Informant Mrs. Florence Wiltzie
Address Brick Dr. - Box 60 - Balto 20 Md.

17. Burial (Burial, cremation, or removal - Which?) Burial Date thereof May 29 1946
(month) (day) (year)
Cemetery or crematory Bethel Hill Cemetery
Location Prince Geo. Co. Md.

18. Funeral director Albert Baker
Address 641-N. 4th St. N.E. Washington D.C.

19. May 26 19 46 Date rec'd by registrar _____ Registrar _____

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 26th 1946 at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 46 to May 26 19 46
and that I last saw him alive on May 24 19 46

Immediate cause of death Myocardial infarction DURATION 1 day

Due to Senility 5 years

Due to -

Other conditions Generalized Atherosclerosis
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Thomas B. Hargley, M.D. M.D. or other _____
Address 815 Eastern Ave Date signed May 26, 1946
Balto 20 Md

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

172
BUREAU OF INVESTIGATION

STANDARD FORM NO. 1

RECEIVED

RECEIVED

JUN 2 1946

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04636

Reg. Dist. No. *XX*

1. PLACE OF DEATH:

County Baltimore County

City or town Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? March 7th, 1946 to May 11th, 1946

Hospital, institution, or street address where death occurred:

Vet. Adm. Hosp. Fort Howard, Maryland

How long in hospital or institution? 3-7-46 to 5-11-46

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Baltimore, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1528 McKean Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war World War I

3.(a) FULL NAME

Frederick L. Reuschling

3.(b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Married

6.(b) Name of husband or wife Blanche Reuschling (wife)

6.(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) January 6th, 1889

8. AGE: Years Months Days If less than one day
57 4 5 hrs. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Painter

11. Industry or business

12. Name Frederick Reuschling

13. Birthplace Maryland

14. Maiden name Catherine Dennis

15. Birthplace Maryland

16. Informant Clinical Records

Address Vet. Adm. Fort Howard, Md.

17. Burial Date thereof 5-15-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baileys, National Cem.

Location Frederick Rd.

18. Funeral director Odd Fellows Home Inc

Address 4644 York Rd #12.

19. 5714 Registrar 46 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 19 46, at 4:35 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 7th 19 46 to May 12 19 46

and that I last saw him alive on May 12th 19 46

Immediate cause of death Heart Disease --

Arteriosclerosis, aortic insufficiency, aortic stenosis, cardiac enlargement, myocardial insufficiency, heart block

Due to

Other conditions

Hypertension, arterial 1 year
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert M. Cullison M. D. or other

R.M. CULLISON, M. D. Clin. Dir. Date signed 5-12-46

Address Vet. Hosp. Fort Howard, Md.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No.

CERTIFICATE OF DEATH

04637

1. PLACE OF DEATH:

(a) County Baltimore
 (b) City or town Reisterstown
 (If outside city or town limits, write RURAL and give town)
 (c) Street address, hospital, or institution Mt. Pleasant Sanatorium
 (d) Length of stay in hospital or inst. (yrs., mos., or days) 6 1/2 years
 (e) Length of stay in this community (yrs., mos., or days) _____

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Maryland (b) County _____
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 3814 Norfolk Ave.
 (If rural give location) _____
 (e) If foreign born, how long in U. S. A.? _____ years

3 (a) FULL NAME

Abraham Rice

3 (b) If veteran, name war

3 (c) Social Security

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 1909

8. AGE:

Years

Months

Days

If less than one day

37216

hr.

min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual occupation Bookkeeper

11. Industry or business

FATHER
MOTHER12. Name Abraham Rice13. Birthplace U. S. A.14. Maiden Name Frances Stokvis15. Birthplace U. S. A.16 (a) Informant Abraham Rice(b) Address 3814 Norfolk Ave.17 (a) Buried (b) Date thereof May 30, 1946

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Baltimore Cemetery

Location

18 (a) Funeral director J. Abrams & Co.(b) Address 3814 Norfolk Ave.19 (a) 5/28/46 (b) 2422 Reisterstown Rd.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. Date of death May 28, 1946 at 1 30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 24, 1937 to May 28, 1946, and that I last saw him alive on May 28, 1946.

Immediate cause of death

Myocardial FailureDue to PulmonaryTuberculosisDue to Tubercular Emphysema

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy Far Advanced Pulmonary
Tubercular Emphysema

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Albert J. Shuler M.D.

M. D. or other

Address Reisterstown, Md. Date signed 5/28/46

Duration

15 years1 1/2 years

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04638

★ Reg. Dist. No. 40

1. PLACE OF DEATH: County <u>Baltimore</u> City or town <u>White Marsh</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>life</u> Hospital, institution, or street address where death occurred: <u>Ebenezer Road</u> Now long in hospital or institution?		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Md.</u> County <u>Balto.</u> City or town <u>White Marsh</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>Ebenezer Road</u> (If rural, give LOCATION) 2.(a) If veteran, name war	
3. (a) FULL NAME <u>BARBARA RIPKE</u>		3. (b) Social Security Number <u>---</u>	
4. Sex <u>female</u> 5. Color or race <u>white</u> 6. (a) Single, married, widowed, or divorced <u>widowed</u>		MEDICAL CERTIFICATION 20. DATE OF DEATH <u>May 21st,</u> 19 <u>46</u> at <u>4:30 P.M.</u> 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>July 4</u> 19 <u>46</u> to <u>April 4</u> 19 <u>46</u> and that I last saw her alive on <u>April 4</u> 19 <u>46</u> Immediate cause of death <u>Cerebral Hemorrhage</u> Due to <u>Hypertensive C.V. disease</u> Due to <u>arteriosclerotic changes</u> Other conditions <u>Gen'l Atherosclerosis</u> (Include pregnancy within 3 months of death) Major findings of operations Date of op. Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically. 22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work?	
6. (b) Name of husband or wife <u>Frank Ripke</u> 6. (c) If alive, give age years 7. Birth date of deceased (mo., day, yr.) <u>January 30, 1877</u> 8. AGE: Years Months Days If less than one day <u>69</u> <u>3</u> <u>21</u> hrs. min. 9. Birthplace <u>Balto. Co., Md.</u> (Town, county, and state) 10. Usual occupation <u>Housewife</u> 11. Industry or business		12. Name <u>Herman Draayer</u> 13. Birthplace <u>Balto. Co., Md.</u> 14. Maiden name <u>Theresa Porter</u> 15. Birthplace <u>Balto. Co., Md.</u> 16. Informant <u>Mrs. John Bowers</u> Address <u>Philadelphia Road</u> 17. <u>burial</u> Date thereof <u>May 23, 1946</u> (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematory <u>Holy Redeemer Cemetery</u> Location <u>Balto., Md.</u> 18. Funeral director <u>Parish Funeral Home</u> Address <u>7401 Belair Road</u> 19. <u>5/22/46</u> 19 <u>46</u> (Date rec'd by registrar) Registrar <u>V. M. Lammert</u>	

RE

MAY 29 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 118

CERTIFICATE OF DEATH

04639

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 days
 Hospital, institution, or street address where death occurred:
Veterans Administration Hospital
 How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 511 N. Washington St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war World War ✓

3. (a) FULL NAME

LAFAYETTE RITZ

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife --
 7. Birth date of deceased (mo., day, yr.) July 31, 1887 6.(c) If alive, give age _____ years
 8. AGE: Years 58 Months 9 Days 25 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)
 10. Usual occupation Unemployed
 11. Industry or business _____
 12. Name August Ritz
 13. Birthplace Baltimore, Md.
 14. Maiden name ? Spaller
 15. Birthplace Baltimore, Md.

16. Informant Clinical Records, Vets. Adm. Hosp.
 Address Fort Howard, Md.

17. Burial May 29, 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Loudon Park Cemetery
 Location Baltimore, Md.

18. Funeral director Ullrich Funeral Home
 Address 2008 Orleans St. Balto. Md.

19. 5/29/46
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 19 46 at 8:35 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 24 19 46 to May 26 19 46
 and that I last saw him alive on May 26 19 46

Immediate cause of death GASTRIC HEMORRHAGE, CAUSE UNDET. DURATION 11 days

Due to _____

Due to _____

Other conditions Anemia, secondary to above 11 days

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert M. Cullison
R. M. CULLISON, CLINICAL DIRECTOR

Address VAH, Fort Howard, Md. Date signed 5/26/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (126)

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Overlea
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 23 yrsHospital, institution, or street address where death occurred:
11 E. Elm Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltimoreCity or town Overlea
(If outside city or town limits, write RURAL and give nearest town)Street No. 11 E. Elm Ave.
(If rural, give LOCATION)2.(a) If veteran, name war no

3.(a) FULL NAME

MARY SIEHLER ROSSMEISL3.(b) Social Security Number
none4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed6.(b) Name of husband or wife Anton Rossmeisl

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 13 18738. AGE: Years 72 Months 8 Days 25 If less than one day
..... hrs. min.9. Birthplace Germany
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Frederick Siehler13. Birthplace France14. Maiden name ? Wurst15. Birthplace Germany16. Informant Mr. Fred. G. Rossmeisl (Son)Address 11 E. Elm Ave. Overlea17. Burial Date thereof May 15, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Matthew's Cem.Location Baltimore Md.HENRY SANDER & SONS, INC.

18. Funeral director

Address North Ave. & Broadway. -1319. 5-15-46 19. 5-15-46
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11, 1946 19. 3.45 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 20 19. 46 to May 11 19. 46
and that I last saw a alive on May 1 19. 46

Immediate cause of death

Heart Coronary Dis. DURATION 1 dayDue to Throm.Due to MyocarditisOther conditions Cholera cythra
of Cholera bacteria ?
(Include pregnancy within 6 months of death)Major findings of operations See this..... Date of op. 5/1/46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

6 N May 11

23. SIGNATURE..... M. D. or other

Address 1520 E. 3rd Date signed 5/12/46

MARGIN RESERVED FOR BINDING

VS ALB

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-0

CERTIFICATE OF DEATH

04641
Reg. Dist. No. 20

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, institution, or street address where death occurred:

How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 27 Wade avenue
(If rural, give LOCATION)

2.(a) If veteran, name war -----

3. (a) FULL NAME
JOHN C. SCANNELL, Sr.

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Margaret Lucey Scannell

6.(c) If alive, give age 85 years

7. Birth date of deceased (mo., day, yr.) June 10, 1860

8. AGE: Years 85 Months 11 Days 18 If less than one day
----- hrs. ----- min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business -----

12. Name Cornelius Scannell

13. Birthplace Ireland

14. Maiden name Johanna Sullivan

15. Birthplace Ireland

16. Informant Miss Margaret Scannell

Address 27 Wade ave. Catonsville

17. Burial Date thereof 5/31/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cathedral

Location Chas. J. Evans & Son, Inc.

18. Funeral address 118 N. Mt. Royal Ave.

19. 5-31 19 46
(Date rec'd by registrar)

MEDICAL CERTIFICATION
20. DATE OF DEATH May 28 19 46 at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 24 19 43 to May 28 19 46
and that I last saw in alive on May 28 19 46

Immediate cause of death Coronary Fibrillation DURATION 2 wks

Due to Cardio-Vascular Renal Disease 3 yrs

Due to -----

Other conditions -----

(Include pregnancy within 3 months of death)

Major findings of operations ----- Date of op. -----

Autopsy results -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ----- Date of -----

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----

Means of injury ----- Injured at work? -----

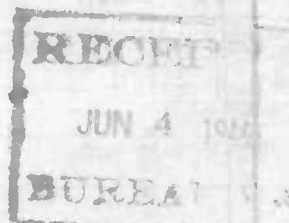
23. SIGNATURE George E. Egan M.D. M. D. or other
Address Catonsville 28 Md Date signed 5-28-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DR. URBAN
803 FREDERICK ROAD



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 670

CERTIFICATE OF DEATH

04642

Reg. Dist. No. 42

1. PLACE OF DEATH: County <u>Baltimore</u> City or town <u>Elkridge</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Baltimore</u> City or town <u>Elkridge</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>Gun Road</u> (If rural, give LOCATION) 2.(a) If veteran, name war			
3. (a) FULL NAME <u>LEONARD A. SCHAAR</u>				3. (b) Social Security Number <u>None</u>			
4. Sex <u>MALE</u>		5. Color or race <u>WHITE</u>		6. (a) Single, married, widowed, or divorced <u>MARRIED</u>			
8. (b) Name of husband or wife <u>ESTELLA M. SCHAAR</u>				7. Birth date of deceased (mo., day, yr.) <u>8 JANUARY 1871</u>			
8. AGE: Years <u>75</u>		Months <u>4</u>		Days <u>22</u>		It less than one day *** min.	
9. Birthplace <u>Baltimore, Maryland</u> (Town, county, and state)							
10. Usual occupation							
11. Industry or business							
FATHER		12. Name <u>Tobias Schaar</u>					
MOTHER		13. Birthplace <u>Germany</u>					
14. Maiden name <u>Caroline Pohlman</u>		15. Birthplace <u>Maryland</u>					
16. Informant <u>Mrs. Estella M. Schaar</u> Address <u>Gun Road, Elkridge, Md.</u>							
17. Burial (Burial, cremation, or removal. Which?) <u>3 June 46</u> (month) (day) (year) Cemetery or crematory <u>Loudon Park Cemetery</u> <u>Baltimore, Maryland</u> Location <u>of R. Schubert & Son</u>							
18. Funeral director Address <u>1300 Buntaw Place</u>							
19. June 1 46 (Date rec'd by registrar) <u>R. W. Hedrick</u> Registrar							
MEDICAL CERTIFICATION 20. DATE OF DEATH <u>30 MAY 1946</u> 19... at <u>10:10 A</u> 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Jan 18 1946</u> to <u>May 30 1946</u> and that I last saw him alive on <u>May 30 1946</u> Immediate cause of death <u>acute coronary</u> <u>obstruction of</u> <u>the myocardial</u> Due to <u>Coronary Disease</u> <u>of Heart</u> Other conditions (Include pregnancy within 3 months of death) Major findings of operations Date of op. Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically. 22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide. Date of Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE <u>R. W. Hedrick</u> M. D. or other Address <u>Elkridge, Md.</u> Date signed <u>5/30/46</u>							

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92-2

CERTIFICATE OF DEATH

04643 16
Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Paradise
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Bonnie View Nursing Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary E. Schneider

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Widowed

6.(b) Name of husband or wife Charles Schneider

7. Birth date of deceased (mo., day, yr.) 8.(c) If alive, give age years

Feb. 28, 1865

8. AGE: Years Months Days If less than one day
81 2 27 hrs. min.9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual occupation At home

11. Industry or business

12. Name August Limpert13. Birthplace Germany14. Maiden name Elizabeth Froehlich15. Birthplace Maryland.16. Informant August SchneiderAddress 305 Greenwood Road,17. Burial Date thereof May 28, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Loudon ParkLocation Baltimore, Md.18. Funeral director Ullrich Funeral HomeAddress 2008 Orleans St.,19. June 28, 46 Ann Hedden
(Dated by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 19 46, at M21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 15 19 45 to May 24 19 46
and that I last saw her alive on May 23 19 46Immediate cause of death arteriosclerotic heart disease DURATION 2 yrsDue to arteriosclerotic hypertension

Due to

Other conditions Senility
(Include pregnancy within 8 months of death)

Major findings of operations. Date of op.

Autopsy results. PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles A. Cahn M. D. or other
Address 2145 W. Balt St Date signed June 25, 46

MARGIN RESERVED FOR BINDING

I

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 532

CERTIFICATE OF DEATH

04644

Reg. Dist. No. 40

1. PLACE OF DEATH: Balto Co
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....md County.....Balto
 City or town.....Fork Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME William A. Scott

3. (b) Social Security Number

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Mar 25 - 1875 6. (c) If alive, give age..... years

8. AGE: Years 71 Months 1 Days md. If less than one day..... hrs. min.

9. Birthplace.....
(Town, county, and state)10. Usual occupation.....F. Corset

11. Industry or business

12. Name.....JAMES SCOTT13. Birthplace.....md14. Maiden name.....Ann J. Mooney15. Birthplace.....& related16. Informant.....Susie R. ScottAddress.....md.

17. Burial..... Date thereof.....Friday
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Fork M. E. CemLocation.....Fork Md.18. Funeral director.....C. E. ArthurAddress.....Fork Md.19. May 16 19 46 C. E. Arthur
(Date recd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....May 14 - 19 46, at 5:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 10, 19 45, to May 14, 19 46, and that I last saw him..... alive on May 14, 19 46.

Immediate cause of death.....Repeated hemorrhage from R. Axilla
 Due to.....Epiosteoma r.v. humeri
 with.....metastases to dm,
 chest wall & lung.

DURATION

1 wk.1 yr.

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?

23. SIGNATURE.....Clifford F. Hudson MD.Address.....Fork Md. Date signed.....5/16/46

100-10

UNITED STATES DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

WASHINGTON, D. C. 20535

MEMORANDUM FOR THE DIRECTOR

SUBJECT:

RE:

DATE:

BY:

RECEIVED
MAY 21 1946
BUREAU VS

ARTISAN LEADER

NO CONTENT

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04645

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 Years
 Hospital, institution, or street address where death occurred:
630 Orpington Rd.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 630 Orpington Rd.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

William A. Scott

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Mary Scott
 7. Birth date of deceased (mo., day, yr.) June 13, 1867
 8. AGE: Years 78 Months 11 Days 12 It less than one day
 B.(c) If alive, give age years
 8. AGE: Years 78 Months 11 Days 12 It less than one day
 hrs. min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)
 10. Usual occupation Machinist-Retired
 11. Industry or business P. R. R.
 FATHER 12. Name Wm. A. Scott
 13. Birthplace Howard Co., Md.
 MOTHER 14. Maiden name Ellen ?
 15. Birthplace Howard Co., Md.

16. Informant Mrs. Mary Scott
 Address 630 Orpington Rd, Baltimore 29

17. Burial Date thereof May 28, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Loudon Park Cem.
 Location Baltimore, Md.

18. Funeral director Wm. J. Tickner & Sons, Inc.
 Address North & Penna Aves. Balto, 17 Md.

19. 5/27 1946 A.W. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1946 at 1:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 10 1946 to May 25 1946
 and that I last saw him alive on May 25 1946

Immediate cause of death Myocarditis (Chronic) DURATION 5 years

Due to
 Due to

Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Eugene S. Passano M. D. or other
5/14 Drury Sim Date signed 5/27/46
 Address

Dr. Eugene Pessagno
513 Drury Lane

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

04646
Reg. Dist. No. 31

1. PLACE OF DEATH

County Baltimore
City or town Randallstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary Louisa Sellers

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

B. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Sept 17, 1877

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

6886Mrs.min.

9. Birthplace

Randallstown Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematorium

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 18, 1946 at 2:40 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 17, 1946 to May 17, 1946
and that I last saw him alive on May 17, 1946

Immediate cause of death

Cancer of stomach

DURATION

1 yr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

May 19, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-0

CERTIFICATE OF DEATH

Reg. Dist. No. 57

04647

1. PLACE OF DEATH:

County Baltimore
 City or town Cockeysville (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Cockeysville (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Sheward Rd
 (If rural, give LOCATION)
 2(a) If veteran, name war

3. (a) FULL NAME

Mary Elizabeth Sheeler

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

F.W.Married

6. (b) Name of husband or wife

Charles E. Sheeler

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age 71 yearsDec. 19, 1880

8. AGE: Years Months Days If less than one day

68512hrs.min.9. Birthplace Balto. Co. Maryland
(Town, county, and state)10. Usual occupation Homemaker

11. Industry or business

12. Name Bradley Sheeler13. Birthplace Balto. Co. Md.14. Maiden name Mary Harrington15. Birthplace Balto. Co., Md.16. Informant Mr. Charles E. SheelerAddress Cockeysville, Md.17. Burial Date thereof June 2-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Ashland PresbyterianLocation Ashland, Balto. Co., Md.18. Funeral director Samson M. BrooksAddress SparksJune 1, 46 Wilmer C. Ensor

19. (Date rec'd by registrar) 19. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1946, at 10:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. alive on 19.

Immediate cause of death

Coronary Atherosclerosis
(?)

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

T. C. de Quincey, M.D.
Cockeysville, Md. Date signed 5/31/46

RECEIVED

JUN 4 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
 County: Baltimore
 City or town: Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 days
 Hospital, Institution, or street address where death occurred:
Opitz Nursing Home
 How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State: Maryland County: _____
 City or town: Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.: 3042 Windsor Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war: _____

3. (a) FULL NAME
Annie Elizabeth Sherwood

3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Wilbur

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1870 6.(c) If alive, give age _____ years

8. AGE: Years 75 Months 7 Days 23 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Milton Frank

13. Birthplace Baltimore, Maryland

14. Maiden name Sarah Colbert

15. Birthplace Baltimore, Maryland

16. Informant Mrs. Gertrude F. Garrett

Address 415 Birch Place, Westfield, N. J.

17. burial Date thereof 5/17/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Parkwood

Location Baltimore County, Maryland

18. Funeral director William Cook, Incorporated

Address 1217 St. Paul Street

19. 5/17/46 46 Supervised
 (Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15, 1946 at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 8, 1946 to May 15, 1946
 and that I last saw him alive on May 15, 1946

Immediate cause of death Cerebral Hemorrhage DURATION 1 wk

Due to Cerebral Arteriosclerosis

Due to Hypertension

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE James E. Howard M. D. or other

Address Baltimore Date signed 4-16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04849

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County... Balto
 City or town... Catonville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... md County... Balto
 City or town... Catonville
 (If outside city or town limits, write RURAL and give nearest town)

Street No... Nursery Lane Catonsville Ave
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Blanche E. Smith

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

John J. Smith

7. Birth date of deceased (mo., day, yr.)

Jan

6. (c) If alive, give age... years

1884

8. AGE:

Years

Months

Days

If less than one day

62

...hrs. ...min.

9. Birthplace

Balto. Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

(Unknown) Etchberger

13. Birthplace

"

14. Maiden name

"

15. Birthplace

"

19. Informant

Hazel Motis (Friend)

Address

534 E. North Ave

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Burial5/22/46

Cemetery or crematory

Balto

Location

" Md.

19. Funeral director

William Cook Inc

Address

1217 St. Paul St.

19.

(Date rec'd by registrar)

5/2146R.W. Hedrick

Registar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 19th 1946 5:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1 1946 to May 19 1946and that I last saw him alive on May 19 1946

Immediate cause of death

Pneumonia of Rectum

DURATION

1 yr

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Lacon, Md Date signed 5/20

MARGIN RESERVED FOR BINDING

VS A15 5-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04650

Reg. Dist. No. 30

1. PLACE OF DEATH:
 County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 months, 3 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 8 months, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Baltimore County Baltimore-5
 City or town Baltimore-5
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 403 N. Curley Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME MARGARET Mary Smith
 3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed
 6. (b) Name of husband or wife Elmer Elsworth Smith
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) December 18, 1864
 8. AGE: Years 81 Months 4 Days 29 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Home
 12. Name John Kronester
 13. Birthplace Germany
 14. Maiden name Margaret Rhinehart
 15. Birthplace Germany

16. Informant Hospital records
 Address Catonsville-28, Md.
 17. Burial Date thereof 5/20/46
 (Burial, cremation or removal, which?) (month) (day) (year)
 Cemetery or crematory Mt Carmel
 Location Balts. Md.
 18. Funeral director William Cook Inc.
 Address 1217 St. Paul St.
 19. 5/20 19 46 A.W. Hedrich
 (To be filled by registrar) (month) (day) (year) Registrar DM

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1946, at 2:10 p.m.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 14 1945 to May 17 1946
 and that I last saw him alive on May 17 1946

Immediate cause of death Pneumonia, left lower lobe
 DURATION 17 das.
 Due to Hypertensive cardiovascular-cerebral disease.
 Indef.

Due to
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE Isadore Tuerk, M.D.
 M. D. or other
 Address Catonsville-28, Md. Date signed 5-17-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH

of deceased is shown on

2411 N. Charles St., Baltimore 102

FILM No. I O 4 MAY 22 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 04651

1. PLACE OF DEATH:

County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 hour
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Md.
How long in hospital or institution? 2 hr.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore St.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 230 N. Amity St.
(If rural, give LOCATION)
2.(a) If veteran, name war WW-I

3.(a) FULL NAME

WALLACE SNOWDEN

3.(b) Social Security Number

4. Sex Male 5. Color or race col. 6.(a) Single, married, widowed, or divorced Married but sep.

6.(b) Name of husband or wife unknown

7. Birth date of deceased (mo., day, yr.) May- 21- 1894 6.(c) If alive, give age years

8. AGE: Years 51 Months 50 Days 11 If less than one day hrs. min.

9. Birthplace Anne Arundel Ct., Md.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name George Snowden

13. Birthplace A.A. Cy., Md.

14. Maiden name Adeline Cortth

15. Birthplace Eastern Shore, Md.

16. Informant Clinical Records, Vets. Adm. Hospital
Address Fort Howard, Md.

17. Burial Date thereof 5-7-1946
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory National Cemetery

Location Irvington, Md.

18. Funeral director Mrs. Katie R. Williams

Address 322 N. Schroeder St. Balto. Md.

19. 5/4/46 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 19 46 at 12:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 2 19 46 to May 2 19 46
and that I last saw him alive on May 2 19 46

Immediate cause of death Pneumonia, right lung;
Lobar pneumonia; Duration unknown.
Due to Cerebral

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert M. Cullison
ROBERT M. CULLISON, M.D. CLIN. DIRECTOR
M. D. or other

Address Fort Howard, Md. Date signed 5-3-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 482

CERTIFICATE OF DEATH

04652

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Balto.City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

7 Overbrook Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)Street No. 7 Overbrook Rd.
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

BESSIE BLANCHE SPICKNALL

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Thomas F. Spicknall

7. Birth date of

deceased (mo., day, yr.)

June 5, 1887

6. (c) If alive, give age years

8. AGE:

Years

58

Months

11

Days

15

If less than one day

hrs. min.

9. Birthplace Seaford, Del.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
MOTHER

12. Name

James Hargus Hutson

13. Birthplace

Delaware

14. Maiden name

Margaret Jennings Smith

15. Birthplace

Delaware16. Informant Mr. Thomas F. Spicknall

Address

7 Overbrook Rd., Catonsville17. Burial
(Burial, cremation, or removal. Which?)Date thereof 5/23/46
(month) (day) (year)

Cemetery or crematory

Woodlawn Cem.

Location

Woodlawn, Md.18. Funeral director WM. J. TICKNER & SONS

Address

Balto., Md.19. 5/23 1946
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20, 1946 at 1:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 19, 1945 to May 20, 1946
and that I last saw him alive on May 19, 1946

Immediate cause of death

Complications of uterine
hernia + adnexia

DURATION

6 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

As aboveDate of op. Feb. 1946

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Mrs. Annant Hood

M. D. or other

Address 2200 Garrison Blvd Date signed 5-22-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-1

CERTIFICATE OF DEATH

04653

Reg. Dist. No. 32
38

1. PLACE OF DEATH

County Baltimore
City or town Rockland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Blanche Alberta Staines

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Howard Hayes Staines7. Birth date of deceased (mo., day, yr.) December 8-1868 8. (c) If alive, give age _____ years8. AGE: Years 77 Months 4 Days 25 If less than one day _____ hrs. _____ min.9. Birthplace Baltimore Co. Maryland
(Town, county, and state)10. Usual occupation At home

11. Industry or business

12. Name William Halbert (HALBERT)13. Birthplace Maryland14. Maiden name Sarah B. Burnett15. Birthplace Maryland16. Informant Mrs. Carrie B. StullerAddress 1303 Appleby Avenue17. Burial, cremation, or removal, Which? Burial Date thereof May 6-1946
(month) (day) (year)Cemetery or crematory Prospect HillLocation Towson, Maryland18. Funeral director Burges Funeral HomeAddress 13631 Falls Road19. 574 Registrar19. 574 Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County BaltimoreCity or town Rockland
(If outside city or town limits, write RURAL and give nearest town)Street No. Falls Road
(If rural, give LOCATION)

2. (a) If veteran, name war _____

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3rd 19 46 at 11 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1936 to May 3rd 1946and that I last saw him alive on May 3rd 1946

Immediate cause of death

DURATION

Chronic Myocarditis2 yrs.

Due to

Hypertension10 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE James P. Gille

M. D. or other

Address Pikesville, Md. Date signed 5/3/46

MARGIN RESERVED FOR BINDING

9-15-15M

VS 415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1066

CERTIFICATE OF DEATH

Reg. Dist. No. 046538

1. PLACE OF DEATH:

County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. 27 W. Penna. Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Sessie Blake Stansbury

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife Henry S. Stansbury
7. Birth date of deceased (mo., day, yr.) Nov. 19, 1875 6.(c) If alive, give age 68 years
8. AGE: Years 70 Months Days It less than one day
hrs. min.

9. Birthplace Balto. City Md.
(Town, county, and state)

10. Usual occupation none

11. Industry or business

12. Name Benson Blake S.

13. Birthplace Calvert Co. Md.

14. Maiden name Jessie Kayle

15. Birthplace Cinn. Ohio

16. Informant Mrs. Henry S. Stansbury

Address 27 W. Penna. Ave. Towson, Md.

17. Burial Date thereof 5/1 29/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Druid Ridge Cemy.

Location Bridgesville, Md.

18. Funeral director John O. Mitchell Sons

Address 1900 Eutaw St. Balt. Md.

19. May 28 19 46 W. Daniel
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 19 46 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 24 19 46 to May 26 19 46

and that I last saw her alive on May 26 19 46

Immediate cause of death Acute Cor. Collapse

DURATION

Due to Myocardial Infarction 2 yrs.

Coronary Arteriosclerosis 2 yrs.

Due to Chronic Bronchitis 2 yrs.

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Daniel J. W. Jones M. D. or other

Address Towson, Md. Date signed 5/28/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 31 1946

BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 04655 38

1. PLACE OF DEATH:

County Baltimore
 City or town Towson 4, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since Sept 11, 1943
 Hospital, institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Md.
 How long in hospital or institution? Since Sept 11, 1943

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore City
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1310 Sergeant St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Beatrice Ann Stoltz

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife William A. Stoltz 6.(c) If alive, give age 31 years7. Birth date of deceased (mo., day, yr.) June 11, 19168. AGE: 30 Years 11 Months 1 Days 1 hrs. 0 min.9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business at home12. Name Beatrice Ann Stoltz13. Birthplace Baltimore, Md.14. Maiden name Ellis15. Birthplace Baltimore, Md.

Personal History- Hospital Records

16. Informant Eudowood Sanatorium, Towson 4, Md.Address Eudowood Sanatorium, Towson 4, Md.17. burial Date thereof 5/15/46
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Western CemeteryLocation on road between Eudowood and Towson18. Funeral director John J. Brown & SonAddress 9010 3rd St. Baltimore 1519. 5/13 46 Registrar One Hiden

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1946 at 1455-9 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 1943 to May 12 1946and that I last saw him alive on May 11 1946

Immediate cause of death

Pulmonary Tuberculosis Since March 1940

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W A Bridges M. D. or otherAddress Towson 4, Maryland Date signed 5-12-46

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04656

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 months
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 7 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Halethorpe
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2824 Ridge Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Gertrude ~~Stine~~ Stine

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife -----
 8.(c) If alive, give age ----- years
 7. Birth date of deceased (mo., day, yr.) September 4 1926
 8. AGE: Years 19 Months 8 Days 21 If less than one day
----- hrs. ----- min.

9. Birthplace Garrett Co. Maryland
 (Town, county, and state)
None
 10. Usual occupation -----
 11. Industry or business -----
 FATHER
 12. Name John William Stine
 13. Birthplace Baltimore, Maryland
 MOTHER
 14. Maiden name Cydney Wilburn
 15. Birthplace Maryland

16. Informant Hospital Records, Spring Grove State
 Address Hospital, Catonsville, 28, Md
 17. Burial Date thereof 5/28-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Western
 Location Edgewoodson Ave
 18. Funeral director Edward Foulson
 Address 2859 Wash Blvd
 19. 5/27 1946 Carroll
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25th 1946 19-----, at 2:00 A M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
October 26, 1945 19----- to May 25 1946
 and that I last saw h er alive on May 25th 1946 19-----

Immediate cause of death Mitral Stenosis
 Due to Subacute Bacterial Endocarditis
 Due to -----
 Other conditions -----

DURATION
Indef.

(Include pregnancy within 3 months of death)
 Major findings of operations -----
 Date of op. -----
 Autopsy results -----
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide ----- Date of -----
 Where did injury occur? ----- (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) -----
 Means of injury ----- Injured at work? -----
 23. SIGNATURE Henry C. A. Mead, M.D.
Henry C. A. Mead, M. D. M. D. or other
 Address Catonsville, 28, Md. Date signed 5/26/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County Balto.City or town Blyndon
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 38 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Balto.City or town Blyndon, md.
(If outside city or town limits, write RURAL and give nearest town)Street No. 15 Chateaufort Ave.
(If rural, give LOCATION)2.(a) If veteran, name war -

3. (a) FULL NAME

Howard Hewitt Stockdale

3. (b) Social Security Number

lost

4. Sex

M.

5. Color or race

W.

6.(a) Single, married, widowed, or divorced

W.

8.(b) Name of husband or wife

Katherine A K Carl8.(c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.)

May 25, 1873

8. AGE:

Years

Months

Days

If less than one day

72.1123- hrs.- min.

9. Birthplace

Reisterstown, Balto. md.
(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

FATHER

12. Name

John Thomas C. Stockdale

13. Birthplace

Don't know

MOTHER

14. Maiden name

Elija Cook

15. Birthplace

Don't know

16. Informant

Carolyn K Simonds

Address

Blyndon

17.

(Burial, cremation, or removal? Which?)

Date thereof

May 20, 1946

Cemetery or crematory

Trinity Lutheran

Location

Reisterstown

18. Funeral director

Address

Rev. B. Perryman & Sons
Reisterstown

19.

(Date rec'd by registrar)

5-20

1946

Dary B. Eline

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/18/46 19 69 at 69 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-5-30 19 30 to 5-18-46 19 46and that I last saw him alive on 5-17-46 19 46

Immediate cause of death

myocarditis - chronic
decompensated

DURATION

2 yr

Due to

hypertension
arteriosclerosis

Due to

chronic nephritis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

L. Saffell M.D.Address Reisterstown, Md. Date signed 5/20/46

RECEIVED
MAY 23 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 046588

1. PLACE OF DEATH: County..... <u>Baltimore</u> City or town..... <u>Towson</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... Hospital, institution, or street address where death occurred: How long in hospital or institution?.....				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>md</u> County..... <u>Balto.</u> City or town..... <u>Towson</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... <u>706 W. Joppa Rd</u> (If rural, give LOCATION) 2.(a) If veteran, name war.....			
3. (a) FULL NAME <u>Albert George Struven</u>				3. (b) Social Security Number			
4. Sex <u>m.</u>		5. Color or race <u>w.</u>		6. (a) Single, married, widowed, or divorced <u>widowed</u>			
6. (b) Name of husband or wife <u>Amelia Gett</u>				6. (c) If alive, give age years			
7. Birth date of deceased (mo., day, yr.) <u>May 5 1852</u>				8. AGE: Years..... Months..... Days..... If less than one day..... hrs..... min.			
9. Birthplace <u>Bremenhaven Germany</u> (Town, county, and state)				10. Usual occupation <u>Retired</u>			
11. Industry or business <u>Peter Struven</u>				12. Name <u>Peter Struven</u>			
13. Birthplace <u>Holland or Germany (border)</u>				14. Maiden name <u>Sophie Luken</u>			
15. Birthplace <u>Holland or Germany (border)</u>				16. Informant <u>Bertha Struven Doeller</u>			
Address <u>706 Joppa Rd. Towson Md</u>				17. (Burial, cremation, or removal. Which?) <u>Burial</u> Date thereof..... <u>May 23 1946</u> (month) (day) (year)			
Cemetery or crematory <u>Lorraine</u>				Location <u>Balto. Md (Woodlawn)</u>			
18. Funeral director <u>Henry M. Jenkins & Son Co</u>				Address <u>McCulloch & Orchard St</u>			
19. (Date rec'd by registrar) <u>May 22 46</u>				Registrar <u>[Signature]</u>			

MEDICAL CERTIFICATION	
20. DATE OF DEATH <u>May 21 st</u> 19 <u>46</u> at <u>8 45</u> A.M.	21. I CERTIFY that death occurred on the date above stated: that I attended deceased from <u>Aug 21 st</u> 19 <u>44</u> to <u>May 21</u> 19 <u>46</u> and that I last saw h. i. m. alive on <u>May 19 th</u> 19 <u>46</u>
Immediate cause of death <u>Old Age</u>	DURATION <u>40 yrs</u>
Due to <u>Generalized arterio-sclerosis</u>	
Due to	
Other conditions (Include pregnancy within 8 months of death)	
Major findings of operations Date of op.	
Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.	
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town)..... (County)..... (State)..... Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?.....	
23. SIGNATURE <u>T. J. Sealbach M.D.</u> <u>200 W. Penna. Ave</u> Address..... <u>Towson Md</u> Date signed <u>5/21/46</u>	

RECEIVED
JUN 2 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04659

Reg. Diat. No. 30

1. PLACE OF DEATH:

County Balto.City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

204 Shady Nook Court Catonsville

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)Street No. 204 Shady Nook Court
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Sophia R. Sumner

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Harry L.7. Birth date of deceased (mo., day, yr.) Oct. - 13 - 1887 6. (c) If alive, give age 46 years8. AGE: Years 68 Months 7 Days 5 If less than one day hrs. min.9. Birthplace Md.
(Town, county, and state)10. Usual occupation none

11. Industry or business

12. Name John Harmon13. Birthplace Germany14. Maiden name unknown15. Birthplace Germany16. Informant Mrs. Charles BruchAddress 304 Shady Nook Court17. Burial Burial Date thereof May - 20 - 46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Landon ParkLocation Balto. Md.18. Funeral director George A. FarleyAddress Fred. & Shady Nook Ave. Catonsville19. 5-20 46 Harold Miller
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1946 at 8:00 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 25 1942 to May 18 1946and that I last saw her alive on May 17 1946Immediate cause of death Pseudo myxoma peritoneiOther conditions Arteriosclerosis of the Coronary
vascular Diseases
(Include pregnancy within 3 months of death)Major findings of operations ?Autopsy results ?

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ? Date of ?

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) (County) (State)

Means of Injury Injured at work?

23. SIGNATURE Carol Hosking M. D. or otherAddress 1326 4th Lombard St Date signed 5/20/46

RECEIVED

MAY 21 1946

BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04568 38

1. PLACE OF DEATH:

County Baltimore
 City or town Towson 4, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since May 2, 1946
 Hospital, institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Md.
 How long in hospital or institution? Since May 2, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Balto City
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5738 Bethel
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Francis Szymanski

3. (b) Social Security Number

215-07-1693

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Theodore Szymanski
 6. (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) Jan. 1919

8. AGE: Years 27 Months 4 Days 4 If less than one day
 hrs. min.

9. Birthplace Baltimore Md
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Stanley Maluszynski

13. Birthplace Poland

14. Maiden name Anna Maria Rysz

15. Birthplace Poland

16. Informant Personal History - Hospital Records

Address Eudowood Sanatorium, Towson 4, Md.

17. Burial Date thereof 5-15-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Stanislaus

Location Baltimore Md.

18. Funeral director George A. Weber

Address 705 S. Ann St

19. 5-13 46 DMH
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1946 at 8:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 2 1946 to May 11 1946
 and that I last saw him alive on May 2 1946

Immediate cause of death Pulmonary tuberculosis

Due to Since May 1938

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W A Bridges M. D. or other

Address Towson 4, Maryland Date signed 5-11-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

04661

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County..... **Baltimore**
 City or town..... **Catonsville**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **10 yrs., 7 mos., 7 days**
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? **10 yrs., 7 mos., 7 days**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... **Maryland** County.....
 City or town..... **Baltimore**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **1404 East Baltimore Street**
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

John Tilsch

3. (b) Social Security Number

4. Sex..... **male** 5. Color or race..... **white** 6. (a) Single, married, widowed, or divorced..... **married**
 6. (b) Name of husband or wife..... **Bartha Freid** 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... **December 28, 1903**
 8. AGE: Years..... **42** Months..... **5** Days..... **-** If less than one day..... hrs. min.
 9. Birthplace..... **Maryland**
 (Town, county, and state)
 10. Usual occupation..... **Cab driver**
 11. Industry or business..... **Taxi**
 FATHER: 12. Name..... **?**
 13. Birthplace..... **?**
 MOTHER: 14. Maiden name..... **?**
 15. Birthplace..... **?**

16. Informant..... **Hospital records**
 Address..... **Catonsville-28, Maryland**
 17. **Burial** Date thereof..... **June 21, 1946**
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... **Spring Grove State Hospital**
 Location..... **Catonsville 28, Maryland**
 18. Funeral director..... **Spring Grove State Hospital**
 Address..... **Catonsville 28, Maryland**
 19. **June 21** 19 **46** **Harry L. Miller** Registrar
 (to be filled by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **May 28** 19 **46** at **12:45 p.m.**
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
October 21 19 **35** to **May 28** 19 **46**
 and that I last saw him alive on **May 28** 19 **46**
 Immediate cause of death.....
Myocardial insufficiency,
chronic, with heart block
 DURATION..... **Indef.**
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)
 Major findings of operations.....
 Date of op.....
 Autopsy results..... **As above**
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?
Isadore Tuerk
 23. SIGNATURE..... **Isadore Tuerk, M.D.** M. D. or other
 Address..... **Catonsville-28, Md.** Date signed..... **6-20-46**

MARGIN RESERVED FOR BINDING

VS A15 9-45-13M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 24 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (834)

CERTIFICATE OF DEATH

04662

Reg. Dist. No. 38

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 9 days

3. (a) FULL NAME Archibald Archie ain

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white widowed

8. (b) Name of husband or wife ? 5. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 8, 1875

8. AGE: Years Months Days If less than one day
70 5 15 hrs. min.9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation Laborer

11. Industry or business ?

12. Name ?

13. Birthplace ?

14. Maiden name ?

15. Birthplace ?

16. Informant Hospital recordsAddress Catonsville-28, Md.17. Burial Date thereof May 27th 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory BaltonLocation E. North Ave. Eib18. Funeral director Leo S. BookAddress 1701-03 N. Patterson Park Ave19. 5-27 46 Harry St. Miller
(County) (Year) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....
 City or town..... Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2 South Patterson Park
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 19 46 at 12:35 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 14 1946 to May 23 19 46
 and that I last saw him alive on May 23 19 46

Immediate cause of death:
Pulmonary oedema
Cachexia
Cerebral arteriosclerosis

DURATION
3 hours
Indef.
"

Due to.....
 Due to.....
 Other conditions Right hemiplegia

(Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.

Autopsy results..... none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

Isadore Fuerk
Isadore Fuerk, M.D.

23. SIGNATURE..... M. D. or other

Address Catonsville-28, Md. Date signed 5-24-46

RECEIVED

MAY 28 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-2)

CERTIFICATE OF DEATH

Reg. Dist. No.

04663

1. PLACE OF DEATH:

County Baltimore
 City or town Owings Mills
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 yrs. 5 mos. 25 days
 Hospital, institution, or street address where death occurred:
Rosewood State Training School
 How long in hospital or institution? 7 yrs. 5 mos. 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5216 Florence Avenue
 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Alverta Vance

3.(b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife
 B.(c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) May 16, 1920
 8. AGE: Years 25 Months 11 Days 17 If less than one day hrs. min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)
 10. Usual occupation none
 11. Industry or business

MOTHER FATHER
 12. Name William G. Vance
 13. Birthplace Baltimore County, Md.
 14. Maiden name Margaret Ely
 15. Birthplace Baltimore Md.

16. Informant Rosewood State Training School
 Address Owings Mills, Md.
 17. Burial Burial Date thereof 5/17/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Cathedral
 Location Baltimore City
C.N. Simon

18. Funeral director C.N. Simon
 Address 4611 Park Heights
 19. 1-6 19 46 Upshaling
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 19 46 at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 8, 1938 to May 3, 1946
 and that I last saw her alive on May 3, 1946

Immediate cause of death
acute myocarditis
& pulmonary edema
 Due to
Chronic myocarditis and
endocarditis
 Due to
 Other conditions Pulmonary Tuberculosis
 (Include pregnancy within 3 months of death) 2 yrs. 10 mos
+

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Isabel H. McClinton M.D.
 Address Rosewood Owings Mills Md. Date signed May 4, 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

04664

P

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 123 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Ft. Howard, MarylandHow long in hospital or institution? 123 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____City or town 702 Bradley Street, Balto, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. See Above

(If rural, give LOCATION)

2.(a) If veteran, name WW-I

3. (a) FULL NAME

FREDERICK WALTON

3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Elizabeth Walton6.(c) If alive, give age 56 years7. Birth date of deceased (mo., day, yr.) 8-10-18898. AGE: Years 56 Months 9 Days 2 If less than one day _____ hrs. _____ min.9. Birthplace Virginia
(Town, county, and state)10. Usual occupation Plaster Work

11. Industry or business _____

12. Name Robert Walton13. Birthplace Virginia14. Maiden name Martha Hall15. Birthplace Virginia16. Informant Clinical Records, Vets. Adm. Hosp.Address Ft. Howard, Maryland17. Burial Date thereof 5-15-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Int. Zion Cem.Location Baltimore Co. Md.18. Funeral director Mrs. Charles A. HemmleyAddress 578 W Biddle St19. 5-14 19 46
(Date rec'd by registrar)Registrar as attachedAddress Ft. Howard, Md. Date signed 5-13-46

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12, 19 46, at 9:45 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 9, 19 46, to May 12, 19 46.and that I last saw him alive on May 12, 19 46.Immediate cause of death Carcinoma of StomachDURATION Unknown

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Biopsy of Cervical lymph node Date of op. _____Autopsy results Carcinoma of stomach

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert M. CullisonR.M. CULLISON, M.D. CH. DIR.Address Ft. Howard, Md. Date signed 5-13-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-8

CERTIFICATE OF DEATH

★ 04665 27
Reg. Dist. No.

1. PLACE OF DEATH:

County: Baltimore County, Md.City or town: Kingsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: New Hampshire County:City or town: Glenn Cliff
(If outside city or town limits, write RURAL and give nearest town)

Street No.

★ If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Donald W Washburn

3. (b) Social Security Number

003-12-4315

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

—

6.(b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

July 2, 1927

6.(c) If alive, give age, years

8. AGE:

Years

Months

Days

If less than one day

181023

.....hrs.min.

9. Birthplace: Wentworth, N. Hampshire
(Town, county, and state)

10. Usual occupation

Soldier

11. Industry or business

U. S. Army

MOTHER

FATHER

12. Name

Claude Washburn

13. Birthplace

Weymouth, Maine

14. Maiden name

Violet Smith

15. Birthplace

Dublin, N. Hampshire

16. Informant

Army Records

Address

Fort George G. Meade, Md.

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof

5/27/46
(month) (day) (year)

Cemetery or crematory

Carson & Swann

Location

Woodville, New Hampshire

18. Funeral director

Edward N. Blight, Jr.

Address

4914 Belair Road

27 May 46

(Date rec'd by registrar)

ALLAN G. BROTZMAN, Lt.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 25, 1946 at 3:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to 19.....

and that I last saw him alive on 19.....

Immediate cause of death

Cerebral concussionpossibly fractures skull and neck

Due to

Auto Accident

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.
Autopsy results Ruptured heart with hemopericardium

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Auto Accident Date of 5/25/46Where did injury occur? Kingsville, New Hampshire
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) RT-1Means of injury Auto Accident Injured at work? No

23. SIGNATURE

Rollin C. Hudson, M.D., D.M.E.

Address

Townsend, N.H.Date signed 5/25/46

RECEIVED

MAY 29 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Arbutus
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

FLORENCE E. WEIBER

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

8. (b) Name of husband or wife

Joseph A. Weiber

7. Birth date of deceased (mo., day, yr.)

18 th. July 1896

6. (c) If alive, give age

54

8. AGE:

Years

49

Months

9

Days

28

If less than one day

***** min.

9. Birthplace

Baltimore Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

At Home

FATHER

12. Name

William H. Stienwedel

13. Birthplace

Baltimore Maryland

MOTHER

14. Maiden name

Estelle T. Woody

15. Birthplace

Baltimore, Maryland

18. Informant

Mr. Joseph A. Weiber

Address

916 Elmridge Road

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

20 May 1946

(month) (day) (year)

Cemetery or crematory

Loudon Park Cemetery

Location

Baltimore, Maryland

18. Funeral director

Address

1300 Eutaw Place

19.

(Date rec'd by registrar)

5/20

46

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore

City or town..... Arbutus
 (If outside city or town limits, write RURAL and give nearest town)

Street No..... 916 Elmridge Road
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number
 NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 16th. May 46 439p M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

November 22 1945 to May 16 1946
 and that I last saw him alive on May 9 1946

Immediate cause of death

Myocardial C. V. Dis.

Due to

Acute Cardiac dilatation

Due to

Other conditions

Acute Pulmonary edema 2 days

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... Dr. J. Earl Pass Earl Pass M.D.
 M. D. or other

Address..... 4001 Wilkens Ave. Date signed..... 5/24/46
4001 Wilkens Ave. S. - 18-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

Reg. Dist. No. 0466744

1. PLACE OF DEATH:

County Baltimore - 19
 City or town Spawass Point
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 years
 Hospital, institution, or street address where death occurred
2605 Lodge Farm Rd.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....
 City or town As in #1
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

THURMOND CORBETT WEST.

3. (b) Social Security Number

223-18-8170

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Married

8. (b) Name of husband or wife

Mabel Page West

7. Birth date of deceased (mo., day, yr.)

May 8, 1918

6. (c) If alive, give age

29 years

8. AGE:

Years

Months

Days

It less than one day

271124

hrs.

min.

9. Birthplace

Nicholas Co. W. Va.
(Town, county, and state)

10. Usual occupation

Ship fitter

11. Industry or business

Ship building

12. Name

Arthur West

13. Birthplace

Charles Co. Va.

14. Maiden name

Ratie Sharper

15. Birthplace

Charles Co. Va.

16. Informant

Mabel West

Address

address as in #1

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof

5/11/46
(month) (day) (year)

Cemetery or crematory

Location

Charlottesville Va.

18. Funeral director

John H. Connelly

Address

418 Eastern Ave. E. 21

19. 5/21

(Date rec'd by registrar)

19

46John H. Connelly

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 1

19

46 at 350 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1944 to May 1 1946
 and that I last saw him alive on April 27 1946

Immediate cause of death

Pulmonary tuberculosis 4 yrs

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury

Injured at work?

23. SIGNATURE

Louis J. Tollin M.D.
Spawass Point Md.
 Date signed May 1, 1946

30810

REC

MAY 14 1946

BUREAU

44-1118

Subj: [illegible]
[illegible]
[illegible]
[illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 984

CERTIFICATE OF DEATH

04668

Reg. Dist. No. 32

1. PLACE OF DEATH:

County Baltimore
 City or town Pikesville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 yrs.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Pikesville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 110 Church Lane
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

JOHN HENRY WINTER

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife _____
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Oct 31, 1864
 8. AGE: Years 81 Months 7 Days 20 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Md
 (Town, county, and state)
 10. Usual occupation Retired
 11. Industry or business _____
 12. Name Frank Winter
 13. Birthplace Germany
 14. Maiden name Louise Plaas
 15. Birthplace Germany

16. Informant Mrs. Charles L. Schanburger
 Address 110 Church Lane, Pikesville, Md
 17. Burial Date thereof May 22 - 46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory New Catholic
 Location Edmondson Ave.

18. Funeral director Frank H. Murrell
 Address Pikesville, Maryland
 19. 5-22-46 Dr. E. E. Nichols
 (Date rec'd by registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20, 1946, at 9 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19, 1946 to May 20, 1946, and that I last saw him alive on May 19, 1946.
 Immediate cause of death _____
 DURATION
Heart Failure 4 days.
 Due to Chronic Myocarditis ①
 Due to Generalized Arteriosclerosis Years.
 Other conditions Sensitization
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE Louis J. Schanburger
1413 Reisterstown Rd M. D. or other
Pikesville Address _____ Date signed 5/20/46

RECEIVED

MAY 23 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

p
04669

Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? LifeHospital, institution, or street address where death occurred: Life

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltCity or town 40 miles
(If outside city or town limits, write RURAL and give nearest town)Street No. 4503 Kenwood Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

John Philip Worth

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Nov 11th

6. (c) If alive, give age

1885

8. AGE:

Years

Months

Days

If less than one day

60

hrs.

min.

9. Birthplace

Baltimore
(Town, county, and state)

10. Usual occupation

Clerk

11. Industry or business

B+ OPR

MOTHER

FATHER

12. Name

John P. Worth

13. Birthplace

Germany

14. Maiden name

Christina Bauer

15. Birthplace

Germany

16. Informant

James W. Worth

Address

704 N. Linwood Ave

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

June 1 -
(month) (day) (year)

Cemetery or crematory

Baltimore Cem

Location

City

18. Funeral director

W. H. Home

Address

2008 Orleans St19. 5/30

(Date rec'd by registrar)

46O. W. Zisch

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1946 at 6:15 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 221946

to

May 281946and that I last saw him alive on May 28 1946

Immediate cause of death

Coronary occlusion

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address 1123 St. Paul St Date signed 5/30/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04670

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore County
 City or town Fort Howard, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12-26-45 to 5-10-46
 Hospital, institution, or street address where death occurred:
Veterans Administration, Fort Howard, Md.
 How long in hospital or institution? 12-26-45 to 5-10-46

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore, Md.
 City or town Essex, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Box # 234 # 13, Cape May Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war World War II

3. (a) FULL NAME

Roland H. Wright

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Nina Wright
 6.(c) If alive, give age 22 years
 7. Birth date of deceased (mo., day, yr.) March 7, 1923
 8. AGE: Years 23 Months 2 Days 4 If less than one day _____ hrs. _____ min.

9. Birthplace Middle River, Maryland
 (Town, county, and state)
 10. Usual occupation Unemployed
 11. Industry or business _____
 12. Name (Deceased) William Wright
 13. Birthplace Baltimore, Md.
 14. Maiden name Annie Lovell
 15. Birthplace Virginia

16. Informant Clinical Records
 Address Veterans Administration, Fort Howard, Md.
 17. Buried Date thereof 5-15-46
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Abraham O. Johnson, Lem.
 Location Eastern Ave.
 18. Funeral director Adel Funeral Home Inc.
 Address 4644 York Rd #12
 19. 5/18/46 19 46
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11, 1946 19 46, at 8:30 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 26th 19 46, to May 11 19 46, and that I last saw him alive on May 11th 19 46.
 Immediate cause of death Cerebral Embolism
 Due to Subacute Bacterial Endocarditis
 Due to Rheumatic Heart Disease
 Other conditions _____

DURATION

2 weeks5 months6 months

(Include pregnancy within 3 months of death)
 Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Robert M. Cullison
R. M. CULLISON, M.D. Clin. Dir. M. D. or other _____
 Address Veterans Hospital, Fort Howard, Md. Date signed 5-12-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address.....

(c) Hospital or institution:

Sparrows Pt. Shipyard(d) Length of stay in hospital or inst. (yrs., mos., or days) *doa*

(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County.....(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *6031 Old Harford Rd*
(If rural give location)(e) Citizen of foreign country? (Yes or No) *✓*
If yes, name country.....

3 (a) FULL NAME

John Zeitvogel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

*Married*6 (b) Name of husband or wife *Anna Braun*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) *July 29, 1901*8. AGE: Years Months Days *44* or less than one day
.....hr.min.9. Birthplace *Austria*

(Town, county, and state)

10. Usual Occupation *Engineer Dredge*11. Industry or business *Standard Oil Co*12. Name *Anton Zeitvogel*13. Birthplace *Austria*14. Maiden Name *Elizabeth Prinz*15. Birthplace *Austria*16 (a) Informant *Mrs Anna Zeitvogel*(b) Address *6031 Old Harford Rd*17 (a) *Burial* (b) Date thereof *5/8/46*

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *New Cathedral*Location *Old Frederick Rd*18 (a) Funeral director *Harry H. Witzko*(b) Address *4101 Edmondson Ave*19 (a) *5-8-46* (b) *Anton Zeitvogel*

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *5-6-1946*, at *7 A*.M

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to *his* death on the day stated above, and death in myopinion resulted from: natural causes ☐, accident ☐, suicide ☐,homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Drowning

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury *5-6-46* at *?* M.(b) Where did injury occur? *Pier I Sparrows Pt.*(c) Did injury occur at home, on farm, industrial place, in public place? *Public* While at work? *?*(d) Means of injury *Found drowned*23. Signature *Thomas J. Malachuk* M.D.Date signed *5-7-46* Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-1

CERTIFICATE OF DEATH

04672

Reg. Dist. No. 30

1. PLACE OF DEATH: Baltimore
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
101 Ingleside Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....Maryland County.....Baltimore
 City or town.....Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....101 Ingleside Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex.....Male 5. Color or race.....White 6. (a) Single, married, widowed, or divorced.....Married
 6. (b) Name of husband or wife.....Regina T. Kieitzyling 6. (c) If alive, give age.....45 years
 7. Birth date of deceased (mo., day, yr.).....June 6, 1892
 8. AGE: Years.....53 Months.....11 Days.....— If less than one day..... hrs. min.

9. Birthplace.....Cassell Co. Md.
 (Town, county, and state)
 10. Usual occupation.....Sexton
 11. Industry or business.....St. Timothy Church
 12. Name.....George Zimmerman
 13. Birthplace.....Unknown
 14. Maiden name.....Catherine Killbaugh
 15. Birthplace.....Unknown

16. Informant.....Mrs. Regina Zimmerman
 Address.....101 Ingleside Ave. Catonsville, Md.
 17. Burial Date thereof.....May 9, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory.....New Cathedral Cem.
 Location.....Old Fried Rd. Balto. Md.
 18. Funeral director.....Easton Sons
 Address.....608 Fried Ave. Catonsville, Md.
 19. 5-8- 1946 Harry H. Miller
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....May 6, 1946 at 4:20 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2, 1945 to May 6, 1946
 and that I last saw him alive on May 6, 1946
 Immediate cause of death.....Chr. Myocarditis
 Due to.....arterio-sclerosis
 Due to.....Hypertension
 Other conditions.....
 (Include pregnancy within 8 months of death)

DURATION

5 yrs

5 yrs

5 yrs

Major findings of operations.....none
 Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?.....
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?.....

23. SIGNATURE.....McKewen, M.D.
203 Ingleside Ave. M. D. or other
 Address.....Catonsville, Md. Date signed.....5/7/46

RECEIVED
MAY 10 1945
BUREAU V. R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 528

CERTIFICATE OF DEATH

04673

Reg. Dist. No. 38

1. PLACE OF DEATH:

County Balto.City or town Parkville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 yrs.

Hospital, institution, or street address where death occurred:

8107 Dalesford Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Parkville
(If outside city or town limits, write RURAL and give nearest town)Street No. 8107 Dalesford Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Frank C. Zinser

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Angela M. Zinser

7. Birth date of

deceased (mo., day, yr.)

Aug. 27th 1890

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

5593

hrs.

min.

9. Birthplace

Balto Md

(Town, county, and state)

10. Usual occupation

Chester

11. Industry or business

Standard Oil Co. Md.

FATHER

12. Name

Geo. V. Zinser

13. Birthplace

Balto. Md.

MOTHER

14. Maiden name

Caroline Evans

15. Birthplace

Germany

16. Informant

Mrs. Frank C. Zinser

Address

8107 Dalesford Rd.

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

6 3 46
(month) (day) (year)

Cemetery or crematory

Maryland Memorial Park

Location

Balto. Co. Md.

18. Funeral director

Fassahn Funeral Home

Address

7401 Belair Rd.

19.

6-1
(Date rec'd by registrar)

19. 46

G. M. Bacon

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30th 1946 at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 2nd 1946 to May 30 1946and that I last saw him alive on May 30 1946

Immediate cause of death

Carcinoma Bladder

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Carcinoma

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. J. Harding MD

M. D. or other

Address

4810 Belair RdDate signed May 31/46

Dr J S Harding

4810 Belair Rd

RECEIVED

JUN 2 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04674

Reg. Dist. No. 31

1. PLACE OF DEATH: Baltimore
County Baltimore
City or town Blond Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County
City or town Blond Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. Eberhart Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Frank Valentine Zoeller

3.(b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
8.(b) Name of husband or wife Lydia E. Zoeller
7. Birth date of deceased (mo., day, yr.) June 26, 1865 8.(c) If alive, give age years
8. AGE: Years 80 Months 10 Days 7 If less than one day hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Book Layer

11. Industry or business

12. Name Frank Zoeller

13. Birthplace Germany

14. Maiden name Mary Ritzke

15. Birthplace Baltimore, Md.

16. Informant Mrs. Albert Kisch

Address Eberhart Ave. Blond Park

17. Burial Date thereof May 6, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory New Cathedral

Location Baltimore Md

18. Funeral director J. Howard Strong

Address 3707 W. North Ave

19. 5/8/46 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1946 at 12:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3 1946, to May 3 1946

and that I last saw him alive on May 3 1946

Immediate cause of death Cancer of Ovary DURATION 1 year

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, tell in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. C. S. MINK M. D. or other

Address 4309 Liberty Ave Date signed May 4

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.